Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Connecticut** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Home and Community Supports Waiver for Persons with Autism

C. Waiver Number:CT.0993

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
11/12/23

Approved Effective Date of Waiver being Amended: 01/01/23

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The intent of this amendment is to transfer the temporary authority of already approved Appendix K provisions to the permanent authorities under this Medicaid waiver. All provisions were previously approved by the Connecticut General Assembly and CMS.

Appendix K provisions are temporary and expire six months following the expiration of the federal public health emergency related to the continued consequences of the Coronavirus Disease (COVID-19) pandemic, in November 2023.

The provisions must be amended into the permanent Medicaid Waivers to ensure the ability to execute section 9817 of the American Rescue Plan Act (ARPA) throughout the ARPA period until March 2025 and to incorporate flexibilities that will be retained in permanent authority that were authorized during public health emergency.

Services will be added to this waiver:

“Training and Counseling Services for Unpaid Caregivers Supporting Participants” will be added. This service is an inter-professional model delivered through a structured number of visits by a team comprised of a Care of Persons with Dementia in their Environments (COPE) certified occupational therapist (OT) and a COPE certified registered nurse (RN) to a participant as defined in the participant’s person-centered plan. The service may include assessment and the development of a home treatment/support/action plan for this service, training and technical assistance to carry out the plan and monitoring of the individual and implementation of the service action plan. For participants without a dementia diagnosis, the service is referred to as “Confident Caregiver.”

Addition of a new service titled “Participant Training and Engagement to Support Goal Attainment and Independence” will be added. This service implements services to the member utilizing the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program model. The CAPABLE program is a set of highly individualized, person-centered services that use the strengths of the participant to improve her/his safety and independence. The CAPABLE program services engage participants to develop action plans with the aim of achieving goals related to increasing functional independence, improving safety, decreasing depression and improving motivation as defined in the person-centered plan.

Addition of Remote Support as a new service (Request for temporary Appendix K authority is still under final review by CMS). This service includes the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Associated changes include expanding the list of authorized providers of PCA services to include adult day providers and remote support providers, adding certified community hubs as authorized provider types, and the addition of new rates for unscheduled back-up PCA services and remote live PCA services.

Adding Environmental Modifications. Environmental Modifications are those physical adaptations to the private residence of the participant or the participant’s family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services must be provided in accordance with applicable state or local building codes.

This waiver maintains a waiting list. The Governor's budget for SFY 2024 has allowed the Department of Social Services to add 120 additional participants in SFY 2025 and 200 in SFY 2026.

Value- based payments will also be added to this waiver.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☒ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☒ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Connecticut** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Home and Community Supports Waiver for Persons with Autism

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Draft ID: **CT.025.02.01**

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/23
Approved Effective Date of Waiver being Amended: 01/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Connecticut's Home and Community Supports Waiver for Persons with Autism will serve persons who are at least 3 years of age with a diagnosis of autism spectrum disorder who live in a family or caregiver's or one's own home. Although these individuals will not have the diagnosis of intellectual disability, they have substantial functional limitations which negatively impact their ability to live independently. These individuals and their caregivers need flexible and necessary supports and services to live safe and productive lives. This waiver will support and encourage the use of consumer-direction to maximize choice as well as control and efficient use of state and federal resources. This waiver is capped at $50,000 annually per participant.

Waiver services will be provided, in the participant's home or in other community settings. An individualized assessment, individual service plan development, and service delivery will emphasize participant strengths and assets, utilization of natural supports and community integration. The waiver will be directly operated by the Department of Social Services, the single state Medicaid authority.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source,

including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The Department of Social Services supports an Autism Advisory Council that has provided input regarding this waiver. The council meets at least 4 times a year and includes DSS staff, consumers, family members, providers and other state agencies.

The state provided both written and electronic notices of the waiver renewal on June 13, 2023 and solicited public input during a 30-day comment period which ended July 13, 2023. No Public comments were received.

Prior to submission, the amendment was presented to the CT legislature's committees of cognizance and a public hearing was held on August 5, 2023. The committees approved the waiver amendment for submission.

The two Connecticut tribes were provided with written notice of the amendments on July 13, 2023 by email. Publication in the CT Law Journal was available for physical review. Additionally, there was a website posting on State of CT Department of Social Services website. The proposed waiver document was available on the State of CT Department of Social Services website as well for review.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Dumont

First Name: Amy

Title: Interim Program Director

Agency: Department of Social Services

Address: 55 Farmington Ave

Address 2:

City: hartford

State: **Connecticut**

Zip: 06106

Phone:

(860) 424-5173 **Ext:** ☐ **TTY**

Fax:
(860) 424-4963

E-mail:
amy.dumont@ct.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:
Dumont

First Name:
Amy

Title:
Program Manager

Agency:

Address:
55 Farmington Ave

Address 2:

City:
Hartford

State: **Connecticut**

Zip:
06106

Phone:
(860) 424-5173 **Ext:** ☐ **TTY**

Fax:

E-mail:
amy.dumont@ct.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

07/19/2023

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Connecticut**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Not applicable

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

All persons participating in this waiver reside in their own or family homes. There are no group housing options available under this waiver. Services are provided either in the community or in the participant's home.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- (●) **The waiver is operated by the state Medicaid agency.**

  Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

  - (●) **The Medical Assistance Unit.**

    Specify the unit name:

    Community Options Unit

    (Do not complete item A-2)

  - ( ) **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

    Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

    (Complete item A-2-a).

- ( ) **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

  Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

MMIS operated through a contract between DSS and Gainwell. DSS contracts with a fiscal intermediary to support individuals who serve as the employer of record, and to process invoices and make payments for services for DSS.

There is a Behavioral Health contracted entity that administers mental health and addiction services for Medicaid recipients throughout the state. They provide a variety of programs with an emphasis on special populations.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Department of Social Services

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

1. The fiscal intermediary is monitored by DSS per the terms of the contract. This includes frequent conference calls, generally quarterly or more frequently on an ad hoc basis and extensive reporting requirements.

2. The fiscal intermediary is subject to audit by the DSS and the State of Connecticut's Auditors of Public Accounts. Records must be made available in CT for the audit.

3. A copy of the most recent financial statement, with an opinion letter from a CPA with a CT license or by a CPA in the state the vendor performs business in, is required as part of the RFP proposal.

4.The fiscal intermediary (FI) must submit an annual cost report for rate analysis. The annual cost report is a report of all expenditures processed by the FI for the fiscal year with the corresponding utilizations. The consolidation of these reports for the FIs are used to develop the final replacement rates used for claimed services.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☒	☐
Review of Participant service plans	☒	☐
Prior authorization of waiver services	☒	☐
Utilization management	☒	☐
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of provider credentialing conducted in accordance with the DSS requirements. Numerator= number of providers credentialed according to DSS requirements Denominator = number of providers credentialed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial provider application packet(all new providers)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted behavioral health ASO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Contracted behavioral health ASO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of records reviewed by DSS that met the LOC requirements. Numerator = number of records that meet LOC Denominator = number of records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: 5 records will be review each quarter by the Medicaid Agency and 100% will be reviewed by DDS Supervisor of Case Manager and the information shared quarterly with DSS.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Issues needing remediation will be identified and discussed at quarterly meetings between DSS, the fiscal intermediary and the behavioral health ASO. A plan for remediation and person(s) responsible will be developed for each item identified as needing improvement. Remediation strategies and progress towards correction will be reviewed and documented at the next meeting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	3		☒
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Each Waiver participant must meet the following criteria:

A primary diagnosis of autism spectrum disorder;
Residency in the State of Connecticut;
Impairment prior to age 22;
Impairment expected to continue indefinitely;
Cognitive and adaptive functioning above the level of intellectual disability (i.e., IQ equal to or greater than 70); and
Substantial functional limitations in two or more of the following areas of major life activity: a) self-care, b) understanding and use of language, c) learning, d) mobility, e) self-direction, f) capacity for independent living.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ○ **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ○ **Other**

    Specify:

- ○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ◉ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The individuals who will be supported by this waiver have less service needs and/or may have many more natural or informal supports available to them. This enables them to take advantage of the flexibility and variety of service options in this waiver in order to remain in their own or family home. Most individuals in this waiver will not require paid 24-hour care or supervision as a waiver service due to the natural or informal supports in place or as a result of the individual's level of supervision needs.

  The cost limit specified by the state is *(select one)*:

  - ◉ **The following dollar amount:**

    Specify dollar amount: 50000

    The dollar amount *(select one)*

    - ○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

◉ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The case manager will initiate the Individual Planning process in advance of enrollment into this waiver. If approved, the participant will complete enrollment in the waiver and the Individual Plan is processed for service authorizations to initiate services. If the plan is not approved, the individual is provided an opportunity to informally negotiate a resolution and is simultaneously notified of his/her fair hearing rights as a result of being denied enrollment in the waiver. The individual budget is determined by the score on the level of need (LON) assessment.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☒ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

If a waiver participant's needs change and he/she requires additional services to meet health and safety needs, the case manager may adjust the service plan based on the LON score up to the maximum allowed in the waiver. If the request exceeds the overall limit of the waiver, DSS may authorize additional funding to ensure the health and safety of the waiver participant until other arrangements can be made (i.e., enhanced supports due to acute medical needs of the participant, or a temporary change in the capacity of natural supports).

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	417
Year 2	580
Year 3	846
Year 4	854
Year 5	863

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- ○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	351
Year 2	480
Year 3	690
Year 4	700
Year 5	710

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Children in the Voluntary Services Program	
Money Follows the Person	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Children in the Voluntary Services Program

Purpose *(describe):*

Children enrolled in the Voluntary Services Program with a diagnosis of autism spectrum disorder as well as emotional, behavioral or substance use disorders that result in the functional impairment of the child which substantially interferes with functioning in the family home and/or community.

Describe how the amount of reserved capacity was determined:

This number is based on the average number of children who are newly enrolled each year. Five are expected to be enrolled each year of the waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved	
Year 1	5	
Year 2	5	
Year 3	5	
Year 4	5	
Year 5	5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Money Follows the Person

Purpose *(describe):*

People who are moving from institutions under Money Follows the Person and transferring to the Autism waiver after 365 days in the community.

Describe how the amount of reserved capacity was determined:

Historical experience with the MFP program.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	2
Year 2	2
Year 3	2
Year 4	2
Year 5	2

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The Department of Social Services maintains a waiting list for this waiver. As slots become available, participants are selected based on their application date.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- ○ **§1634 State**
- ○ **SSI Criteria State**
- ◉ **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☒ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- ☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group**

under 42 CFR §435.217.

Select one and complete Appendix B-5.

- ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

  Check each that applies:

  - ☒ **A special income level equal to:**

    Select one:

    - ◉ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

      Specify percentage:
    - ○ **A dollar amount which is lower than 300%.**

      Specify dollar amount:
  - ☒ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
  - ☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
  - ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
  - ☐ **Aged and disabled individuals who have income at:**

    Select one:

    - ○ **100% of FPL**
    - ○ **% of FPL, which is lower than 100%.**

      Specify percentage amount:
  - ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

    Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by

law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the state plan**

(*select one*):

○ **The following standard under 42 CFR §435.121**

Specify:

- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**

(*select one*):

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

Specify percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state Plan**

Specify:

- ○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ◉ **The following formula is used to determine the needs allowance:**

Specify:

200% of the Federal Poverty Level

- ○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable**
- ○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **The following standard under 42 CFR §435.121**

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

- (●) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The special income level for institutionalized persons**
- (●) **A percentage of the Federal poverty level**

Specify percentage: 200

- ( ) **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- ( ) **The following formula is used to determine the needs allowance:**

Specify formula:

- ( ) **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The state does not establish reasonable limits.**
- ( ) **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ◉ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Case managers, case manager supervisors or other DSS staff or clinicians providing services to waiver participants who meet the following Qualified Intellectual Disabilities Professional (QIDP) standards:

An individual who has received: at least a bachelor's degree from a college or university (master and doctorate degrees are also acceptable) and has received academic credit for a major or minor coursework concentration in a human services field. Human services field includes all academic disciplines associated with the study of: human behavior (e.g., psychology, sociology, speech communication, gerontology, etc.), human skill development (e.g., education, counseling, human development), humans and their cultural behavior (e.g., anthropology), or any other study of services related to basic human care needs (e.g., rehabilitation counseling), or the human condition (e.g., literature, the arts) and who has demonstrated competency to do the job.

The DSS Case manager and DSS Supervisors provide case management for the individuals on the waiver. They Perform activities related to individual services plans for conformity with federal and/or agency standards; coordinates and monitors the delivery of waivered services to ensure the federal requirements for reimbursement are met and maintained and monitors completion of appropriate documentation; develops social service evaluations and service recommendations; oversees and supports continuity of care and waiver benefits; monitors development and ensures maintenance of individual files including required documentation; provides information and support to individuals and families in obtaining and maintaining social services benefits to ensure continued waiver eligibility; provides guidance and support to individual and/or family members in locating appropriate providers in the community; convenes, chairs and facilitates interdisciplinary/planning support team meetings to develop, review and/or modify individual service plans; coordinates integration of day program, residential, medical and other services provided to each individual and ensures service delivery; assists with identifying the need for evaluations, scheduling of evaluations and monitors completion; acts as liaison and provides technical assistance to service providers and monitors compliance with departmental and waiver policies and procedures; maintains regular contact and provides supportive guidance to assigned individuals and their families; gives information to individuals and/or call-in’s, guardians and families regarding their legal rights, departmental policies and procedures, services provided and encourages participation in service planning process; schedules program reviews and monitors implementation of specific program recommendations; ensures that legal and financial documents are completed in a timely manner.
Ongoing competency is evaluated through supervision, training and oversight provided by a Supervisor of Case Management and Annual Performance Review is required for all case managers.

Case Management staff do not provide services.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

There is reasonable indication that the person, but for the provision of waiver services, would require placement in an ICF/IID. The person requires assistance due to one or more of the following:

1. Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative support in performing self-care and daily activities;
2. Has a deficit in self-care and daily living skills requiring habilitative training;
3. Has a maladaptive social and/or interpersonal patterns to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training.

This determination is made through a planning and support team process utilizing the CT Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of an individual's level of support needs and identification daily living. The LON is a comprehensive assessment of an individual's level of support needs and identification of risk areas in the following domains: health/medical, pica, behavior, psychiatric, criminal/sexual, seizure, mobility, safety, comprehension and understanding, social life, communication, personal care, and daily living. The composite score on the CT LON is used to validate the participant's level of care. A composite score of 1 or greater on this tool is required in order to show that the participant requires an ICF/IID level of care. The scoring algorithm used to calculate the composite score incorporates the scores from the domains listed above and results in an overall score ranging from 1 to 8.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

This determination is made through a planning and support team process utilizing the CT Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of an individual's level of support needs and identification of risk areas in the following domains: health/medical, pica, behavior, psychiatric, criminal/sexual, seizure, mobility, safety, comprehension and understanding, social life, communication, personal care, and daily living The Composite Score on the CT LON is used to validate the participant's level of care. A composite score of 1 or greater on this tool is required in order to show that the participant requires an ICF/IID level of care. The scoring algorithm used to calculate the composite score incorporates the scores from the domains listed above and results in an overall score ranging from 1 to 8. The DSS case manager completes the initial, or reviews the existing, CT LON assessment and makes updates as required by changes in the individual. The score on the CT LON determines whether or not the participant meets, or continues to meet, the ICF/IID level of care.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

The electronic consumer information system (eCAMRIS) maintains the date of the last annual Individual Plan review. The level of care determination is completed at the time of each review. The case manager and case manager supervisor use this system as a tickler system.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All future evaluations will be stored in the web-based application. In addition, the initial evaluations are maintained in the individual's DSS records.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of applicants who received an initial level of care determination prior to receipt of waiver services. Numerator = number of applicants who received an initial level of care determination Denominator = number of applicants

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of LOC determinations that were completed by a QMRP (Qualified Mental Retardation Professional). Numerator= number of LOC determinations completed by QMRP (Qualified Mental Retardation Professional) Denominator= total number of LOC determinations

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number of/percent of participants' initial, or annual, or both, LOC determinations that were completed acurately as required by the state utilizing the approved LON instrument. Numerator= number of level of care determinations utilizing the approved level of care tool Denominator = total number of level of care determinations

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The autism waiver manager notifies the case managers and supervisory staff in writing of findings from individual initial enrollment reviews and record audits. Corrective actions are completed by the case managers within 30 days and results reported back to the autism waiver manager. If action is not corrected, staff performing LOC will be retrained on timeframes and/or LOC instrument.

The DSS supervisor of the Case Managers ensures remediation of any individual or case manager specific issues identified in the LOC determination review.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals seeking services are notified of the alternatives available under the waiver and are informed of their option to choose institutional or waiver services by the case manager. The waiver recipient's decision is documented on the waiver application (Form 219e) and included in the waiver recipient's record.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The case management record, paper and/or electronic, will maintain all Freedom of Choice forms for waiver participants in the DSS office and in the participant's individual record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

DSS prepares HCBS waiver informational materials in English and Spanish and posts both to the DSS website. Additionally, DSS utilizes a Language Line service to ensure that all individuals who call DSS will have the availability of a language interpreter service immediately upon the call. DSS policy states that language interpretation service will be provided free of charge at all intake, formal planning meetings, hearings or informal dispute resolution process sessions. Once enrolled in an HCBS waiver, interpreter services are also included as a covered waiver service for other purposes as detailed in the plan.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Live in Companion
Statutory Service	Respite
Other Service	Assistive Technology
Other Service	Clinical Behavioral Support Services
Other Service	Community Mentor
Other Service	Enviornmental Accessibility Adaptations
Other Service	Individual Goods and Services
Other Service	Interpreter
Other Service	Job Coaching
Other Service	Life Skills Coach
Other Service	Non-Medical Transportation
Other Service	Nutrition
Other Service	Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)
Other Service	Personal Emergency Response System
Other Service	Remote Supports
Other Service	Social Skills Group
Other Service	Specialized Driving Assessment
Other Service	Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):

Live in Companion

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Service is intended to be used by participants who are capable of being alone for significant periods of time but who may be afraid to be alone at night or who may need assistance with accessing help in an emergency situation at night. The Live-in Companion agrees to provide regular companionship and support should an emergency arise. Other informal supports such as occasional transportation, assistance with meal preparation or participating in an activity such as going to the movies or bowling, may be provided by the Live-in Companion without any payment for support.
The residence must be leased or owned by consumer, his/her family or legal representative. The Live-in Companion cannot be related to the consumer. The services under the Live in Caregiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals hired by participant who self direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Live in Companion

Provider Category:

Individual

Provider Type:

Individuals hired by participant who self direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that employees meet the following qualifications:
Prior to Employment
21 yrs of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
Demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
Demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
Demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
Ability to participate as a member of the team if requested by the individual
Demonstrate understanding of person center planning
Must pass competency tests for Autism Program Orientation Training Level I and II within three months.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FI

Frequency of Verification:

Prior to Employment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Relatives/Legal Guardians who reside in the same household as the individual may not provide respite.
The services under the Respite service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite may be provided for up to 30 consecutive days. Respite services beyond 30 consecutive days will require review and prior approval from DSS.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private providers
Individual	Individuals hired by participants who self-direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Private providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Facilities and/or entities and individuals certified in accordance with subsection (d) of Section 17a-218, or otherwise certified as a qualified provider of respite service by DDS.

Other Standard *(specify):*

The agency ensures that employees meet the following qualifications:

Prior to Employment
18 years of age
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer
criminal background checks
registry checks

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; mandated child abuse reports; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the service plan
ability to participate as a member of the team
demonstrate knowledge of person-centered planning
must pass competency tests for Autism Program Orientation Training Level I and II within three months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Initial and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individuals hired by participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that employees meet the following qualifications:

Prior to Employment
18 years of age
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer
Criminal background checks

Prior to being alone with the individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; mandated child abuse reports; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the plan
ability to participate as a member of the team
must pass competency tests for Autism Program Orientation Training Level I and II within three months.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI

Frequency of Verification:

Prior to employment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:
a) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
b) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participant;
c) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
d) training or technical assistance for the participant, or, where appropriate, the family members or authorized representatives of the participant; and
e) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the participant.
The services under Assistive Technology are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Items available under the individual's medical insurance are excluded. May use up to $5000 for a 5-year period. Prior approval for these devices is required.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vendors of Assistive Technology

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:

Vendors of Assistive Technology
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Private Vendors: Conn. State Agency Reg. Section 10-102-3(e)(8)

Dept. of Admin. Services Bureau of Purchasing/Purchasing Manual 11/91

Direct Purchase Activity No. 8-F (CGS 4a-50 and 4a-52).

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Prior to providing service

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Clinical Behavioral Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition (Scope):

These are clinical and therapeutic services which are not covered by the Medicaid State Plan, necessary to improve the individual's independence and inclusion in their community. This service is available to individuals who demonstrate an issue that results in the functional impairment of the individual and substantially interferes with or limits functioning at home or in the community. Clinical Behavioral Support services to include: 1) Assess and evaluate the behavioral and clinical need(s); 2) Develop a behavioral support plan that includes intervention techniques as well as teaching strategies for increasing new adaptive positive behaviors, and decreasing challenging behaviors addressing these needs in the individual's natural environments; 3) Provide training to the individual's family and the support providers in appropriate implementation of the behavioral support plan and associated documentation; and 4) Evaluate the effectiveness of the behavioral support plan through the use of data analysis by monitoring the plan on a monthly basis, and by meeting with the team one month after the implementation of the behavioral plan, and in future intervals as needed. The service will include any changes to the behavioral plan when necessary and the professional(s) shall be available to the team for questions and consultation. The professional(s) shall make recommendations to the individual's support team and case manager for referrals to community physicians and other clinical professionals that support the recommendations of the assessment findings as appropriate. Use of this service requires the preparation of a formal comprehensive assessment and submission of any restrictive behavioral support program to the DSS for approval prior to implementation. Service can be provided face to face or using alternate means by all provider types.
The Autism Waiver Case Managers will be responsible for adding the service to the client’s care plan that involves an alternate means of the delivery. Provider reports will indicate how the service was delivered as will a billing procedure code modifier to indicate an alternative means of service delivery. Providers for this service do not oversee the plan for the client. Autism Waiver Case Managers are responsible for oversight of client's services, overall plan and documentation of Services and service delivery.
Allowing services to be delivered in an alternative way will enable individuals to still receive services when they are unable leave their home environment and remain safe and successful.
By allowing life Behavioral Consultant services to be delivered in a virtual means important services in a client's plan can contribute to enhanced and increased independence by not allowing any interruption in services,
Delivering services in alternate means can continue to teach skills that are important to the participant for community interaction and integration.The participant will need to attest that they are in a private place in their environment, they consent to the alternatively delivered service and this will need to be documented in the providers report.
Any remote monitoring will meet HIPAA requirements and be accepted by the state’s HIPAA compliance officer. This will be documented in the provider report and the case manager will document on client's service plan. The Case manager will assess back up plan prior to implementation and/or authorization of remote monitoring.
The use of remote monitoring and associated equipment will be individualized assessment and a part of the person-centered service plan. Ongoing monitoring and evaluation will be in place to confirm ongoing need for remote monitoring vs. in person services and supports. The state does not plan to utilize cameras that the individual does not have control over. During development of person-centered service plan, participant will be advised of option to turn off remote monitoring device and/or equipment. Telephonic and virtual technology with 2-way video capability will be used.
The State does not provide the participant with equipment. The equipment being used is their own device which could be a laptop computer, tablet, telephone, or cellphone. The participant will know when their own equipment is in use. They will have the ability to relocate their own equipment to the setting in their environment in which they are most comfortable completing the visit.
In-person activities continue to be a priority for the participant and telehealth will be used to supplement the scheduled in-person service based on the person-centered planning process.

The case manager should be notified as they could arrange for assistance as a contingency plan when there are connectivity or device problems during the delivery of services.

Clinical Behavioral Support Services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Specialist
Individual	Professional Counselor
Individual	Psychologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Clinical Behavioral Support Services

Provider Category:

Individual

Provider Type:

Behavior Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

BCBA National Certification

Other Standard *(specify):*

Verification will occur to ensure employees meet the following qualifications:

Prior to Employment
21 years of age
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence in knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
ability to participate as a member of the team if requested by the individual or guardian
demonstrate understanding of person-centered planning
demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS or its behavioral health ASO

Frequency of Verification:

Initially and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Clinical Behavioral Support Services

Provider Category:

Individual

Provider Type:

Professional Counselor

Provider Qualifications

License *(specify):*

Master's degree in psychology, social work or a related field, special education certification. Proof of licensure or certification per CGS Chapter 383b (Licensed Clinical Social Worker), or licensure per CGS Chapter 383a or 383c (Marriage and Family Therapist or Professional Counselor) as applicable.

Certificate *(specify):*

Other Standard *(specify):*

Verification will occur to ensure employees meet the following qualifications:

Prior to Employment
21 yearsrs of age
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence in knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
ability to participate as a member of the team if requested by the individual or guardian
demonstrate understanding of person-centered planning
demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS or its behavioral health ASO

Frequency of Verification:

Initially and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Clinical Behavioral Support Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Doctorate and current licensure in psychology (Licensure per CGS Chapter 383)

Certificate *(specify):*

https://wms-mmdl.cms.gov/WMS/faces/protected/35/apdxC1_1b.jsp#

Other Standard *(specify):*

Verification will occur to ensure employees meet the following qualifications:

Prior to Employment
21 years of age
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence in knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
ability to participate as a member of the team if requested by the individual or guardian
demonstrate understanding of person-centered planning
demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS and/or its behavioral health ASO

Frequency of Verification:

Initially and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Mentor

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Assistance necessary to meet the individual's day-to-day activity and daily living needs and to reasonably assure adequate support at home and in the community to carry out personal outcomes. Cueing and supervision of activities is included. This service may not be used in place of Medicaid State Plan Home Health Aide services for which the participant is eligible. Provision of service takes place in the participant's home and/or in their community.
The services under the Community Mentor Service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals hired by participants who self-direct
Agency	Qualified providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Mentor

Provider Category:

Individual

Provider Type:

Individuals hired by participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that employees meet the following qualifications:

Prior to Employment
18 years of age
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the Individual Plan
demonstrate knowledge of person-centered planning
ability to participate as a member of the team

Verification of Provider Qualifications

Entity Responsible for Verification:

FI

Frequency of Verification:

Prior to employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Mentor

Provider Category:

Agency

Provider Type:

Qualified providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to Employment:
18 years of age
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the Individual Plan
ability to participate as a member of the team demonstrate knowledge of person-centered planning
must pass competency tests for Autism Program Orientation Training Level I and II.

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS and/or its behavioral health ASO

Frequency of Verification:

Initial and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Enviornmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Environmental Adaptations are those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services must be provided in accordance with applicable state or local building codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

$15,000 over a 3 year period

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private contractor/business
Individual	Non-relative able to meet individual's needs

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enviornmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Private contractor/business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A DORS approved contractor
Home Improvement Registration by the Dept. of Consumer Protection Adheres to State/Local Building Codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and then each 2 years following

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enviornmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Non-relative able to meet individual's needs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Services, equipment or supplies that will provide direct benefit to the individual and support specific outcomes identified in the Individual Plan. The service, equipment or supply must either reduce the reliance of the individual on other paid supports, be directly related to the health and/or safety of the individual in his/her home, be habilitative or rehabilitative in nature and contribute to an individuals outcome, enhance the individual's ability to be integrated into the community, provide resources to expand self-advocacy skills and knowledge, and, the individual has no other funds to purchase the described goods or services. This service may be used only by participants who use participant-directed services. This service may not duplicate any Medicaid State Plan service. It may not cover room and board and may not cover any purchases of meals or food. Must be pre-approved by case manager supervisor and will be written in the Individual Plan outcomes and in the individual budget.
The services under the Individual Goods and Services service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The value of individual goods and services cannot exceed $1000.00 per year.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals hired by participants who self-direct
Agency	Private agency or private vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:

Individual

Provider Type:

Individuals hired by participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that employees meet the following qualifications:

Prior to Employment
21 years of age
possess a high school diploma
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
ability to participate as a member of the team
demonstrate understanding of person-centered planning
must pass competency tests for Autism Program Orientation Training Level I and II within three months.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI

Frequency of Verification:

Prior to employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:

Agency

Provider Type:

Private agency or private vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets any applicable state regulations for the type of supply or service as described in the approved Individual Plan. If the participant is purchasing direct supports, the agency will ensure that employees meet the following qualifications prior to employment:

Prior to Employment
21 years of age
possess a high school diploma
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
ability to participate as a member of the team
demonstrate understanding of person-centered planning
must pass competency tests for Autism Program Orientation Training Level I and II within three months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Initially and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Interpreter

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Service of an interpreter to provide accurate, effective and impartial communication where the waiver recipient or representative is deaf, hard of hearing or where the individual does not understand spoken English.
The services under the Interpreter service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private or public translation agencies
Individual	Individuals hired by participants who self-direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Interpreter

Provider Category:
Agency
Provider Type:

Private or public translation agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified to provide Interpreter Services by DDS.

Sign language interpreter: Certified by National Association of the Deaf or National Registry of Interpreters for the Deaf.
Sign language interpreters must be registered with the Department of Aging and Disability Services.

Other Standard *(specify):*

For any other language interpreter the agency will verify that the person meets the following qualifications:

Prior to Employment
21 years of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
be proficient in both languages
be committed to confidentiality
understand cultural nuances and emblems
understand the interpreter's role to provide accurate interpretation

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Initial and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Interpreter

Provider Category:

Individual

Provider Type:

Individuals hired by participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Sign language interpreter: Certified by National Association of the Deaf or National Registry of Interpreters for the Deaf.
Sign language interpreters must be registered with the Department of Aging and Disability Services.

Other Standard *(specify):*

For any other language interpreter the FI will verify that the person meets the following qualifications:
Prior to Employment
21 years of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
be proficient in both languages
be committed to confidentiality
understand cultural nuances and emblems
understands the interpreters role to provide accurate interpretation

Verification of Provider Qualifications

Entity Responsible for Verification:

FI

Frequency of Verification:

Prior to employment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Job Coaching

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Job Coaching includes activities needed to sustain paid work by participants, including supervision and training. When Job Coaching is provided at a work site where persons without disabilities are employed, payment is made only for adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting.

Job Coaching does not include sheltered work or similar types of vocational services furnished in specialized facilities. Job Coaching may be furnished to participants who are paid at a rate at or more than minimum wage, provided that the participant requires the supports in order to sustain employment. Job Coaching may include services and supports that assist the participant in developing, and achieving self-employment through the operation of a business and may be used to support a participant in a volunteer experience for the sole purpose of developing employment experiences and skills needed for employment in the general workforce.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs;
3. Payments for vocational training that is not directly related to a participant's supported employment.

Documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) is maintained in the file of each individual receiving this service.

Prior approval is required for this service.
The services under the Job Coaching service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private providers
Individual	Individuals hired by participants who self-direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Job Coaching

Provider Category:

Agency

Provider Type:

Private providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that employees meet the following qualifications:

Prior to Employment
21 years of age
bachelor's degree from an accredited institution of higher education
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence in knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the Individual Plan
ability to participate as a member of the team. demonstrate understanding of person-centered planning

Must pass competency tests for Autism Program Orientation Training Level I and II within three months of working with an individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Initial and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Job Coaching

Provider Category:

Individual

Provider Type:

Individuals hired by participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that employees meet the following qualifications:

Prior to Employment
21 years of age
bachelor's degree from an accredited institution of higher education
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence in knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the Individual Plan
ability to participate as a member of the team
demonstrate understanding of person-centered planning

Must pass competency tests for Autism Program Orientation Training Level I and II within three months of working with an individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI

Frequency of Verification:

Prior to employment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Life Skills Coach

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Life Skills Coaching assists individuals with the acquisition, improvement and/or retention of skills and provides necessary support to achieve personal outcomes that enhance an individual's ability to live and work in their community as specified in the Individual Plan of care. This service is intended for specific instruction and training in a personal outcome. Provision of the service is limited to the person's own, foster home or family home and/or in their community. This service may be self-directed or provided through a qualified agency. Life skills coaching may include any or all of the following activities:
- Implementation of strategies to address behavioral, medical, medication management or other needs identified in the Individual Plan.
- Implementation of therapeutic recommendations including speech, communication, social skills, leisure/recreation skills, O.T., P.T., and assistance in following special diets and other therapeutic routines
- Provide training or practice in basic consumer skills such as banking, budgeting, and shopping
- Provide instruction and training in one or more need areas to enhance the person's ability to live and work in the community
- Assist the individual to complete daily living activities, including personal care and assistance to access other community resources. Services can be provided face to face or using alternate means by all provider types.
The Autism Waiver Case Managers will be responsible for adding the service to the client’s care plan that involves an alternate means of the delivery. Provider reports will indicate how the service was delivered as will a billing procedure code modifier to indicate an alternative means of service delivery.
Allowing services to be delivered in an alternative way will enable individuals to still receive services when they are unable leave their home environment and remain safe and successful.
By allowing life skills services to be delivered in a virtual means important services in a client's plan can contribute to enhanced and increased independence by not allowing any interruption in services,
Delivering services in alternate means can continue to teach skills that are important to the participant for community interaction and integration.The participant will need to attest that they are in a private place in their environment, they consent to the alternatively delivered service and this will need to be documented in the providers report.
Any remote monitoring will meet HIPAA requirements and be accepted by the state’s HIPAA compliance officer. This will be documented in the provider report and the case manager will document on client's service plan.
Case manager will assess back up plan prior to implementation and/or authorization of remote monitoring.
The use of remote monitoring and associated equipment will be individualized assessment and a part of the person-centered service plan. Ongoing monitoring and evaluation will be in place to confirm ongoing need for remote monitoring vs. in person services and supports. The state does not plan to utilize cameras that control does the individual have over the equipment. During development of person-centered service plan, participant will be advised of option to turn off remote monitoring device and/or equipment. Telephonic and virtual technology with 2-way video capability will be used.

The State does not provide the participant with equipment. The equipment being used is their own device which could be a laptop computer, tablet, telephone, or cellphone. The participant will know when their own equipment is on use. They will have the ability to relocate their own equipment to the setting in their environment in which they are most comfortable completing the visit.

In-person activities continue to be a priority for the participant and telehealth will be used to supplement the scheduled in-person service based on the person-centered planning process.

The services under Life Skills Coach are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals hired by participants who self-direct
Agency	Private providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Life Skills Coach

Provider Category:

Individual

Provider Type:

Individuals hired by participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that employees meet the following qualifications:

Prior to Employment
21 years of age
High school diploma or equivalent. May posses a bachelor's degree from an accredited institution of higher education, however it is not mandatory
possess a valid Connecticut driver's license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the Individual Plan
ability to participate as a member of the team
demonstrate knowledge of person-centered planning

Must have experience working with those on the Autism Spectrum

Verification of Provider Qualifications

Entity Responsible for Verification:

FI

Frequency of Verification:

Prior to employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Life Skills Coach

Provider Category:

Agency

Provider Type:

Private providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency will ensure that employees meet the following qualifications :

Prior to Employment

21 years of age
possess a valid Connecticut driver's license
Must have a high school diploma or equivalent.
bachelor's degree from an accredited institution of higher education is accepted but not a requirement
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; incident reporting; mandated child abuse reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the Individual Plan
ability to participate as a member of the team
demonstrate knowledge of person-centered planning
must have knowledge or have worked with individuals on the Autism Spectrum.

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Initial and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the Individual Plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the Individual Plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.
The services under the non medical transportation service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private providers
Individual	Individuals hired by participants who self-direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:

Private providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency will ensure that employees meet the following qualifications:

Valid Connecticut driver's license
Proof of insurance if transporting in employee's vehicle
21 years of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence in knowledge of state policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting use of physical management techniques.

Insurance
In the absence of specific Agency requirements, the Contractor shall obtain and maintain the following insurance coverage at its own cost and expense for the duration of the Contract:

(a) Commercial General Liability. $1,000,000 combined single limit per occurrence for bodily injury, personal injury and property damage. Coverage shall include Premises and Operations, Independent Contractors, Products and Completed Operations, Contractual Liability, and Broad Form Property Damage coverage. If a general aggregate is used, the general aggregate limit shall apply separately to the services to be performed under this Contract or the general aggregate limit shall be twice the occurrence limit;

(b) Automobile Liability. $1,000,000 combined single limit per accident for bodily injury. Coverage extends to owned, hired and non-owned automobiles. If the vendor/contractor does not own an automobile, but one is used in the execution of this Contract, then only hired and non-owned coverage is required. If a vehicle is not used in the execution of this Contract then automobile coverage is not required.

(c) Professional Liability. $1,000,000 limit of liability, if applicable; and/or

(d) Workers' Compensation and Employer's Liability. Statutory coverage in compliance with the compensation laws of the State of Connecticut. Coverage shall include Employer's Liability with minimum limits of $100,000 each accident, $500,000 Disease – Policy limit, $100,000 each employee.

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Initial and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individuals hired by participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual Provider: Valid Connecticut driver's license and insured vehicle.

Verified by the FI:

Prior to Employment
21 years of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques

Verification of Provider Qualifications

Entity Responsible for Verification:

FI

Frequency of Verification:

Prior to employment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nutrition

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Clinical assessment and development of special diets, positioning techniques for eating; recommendations for adaptive equipment for eating and counseling for dietary needs related to medical diagnosis for participants and training for paid support staff to ensure compliance with the participant's dietary needs. The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to 25 hours of service per year and will require prior authorization from the case manager.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	
Agency	

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutrition

Provider Category:
Individual
Provider Type:

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Dietitian/Nutrition- Certification per CGS Chapter 384b
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

FI responsible for Verification
Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutrition

Provider Category:
Agency
Provider Type:

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Dietitian/Nutrition- Certification per CGS Chapter 384b

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

FI responsible for Verification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The CAPABLE program is a set of highly individualized, person-centered services that use the strengths of the participant to improve her/his safety and independence. The CAPABLE program services engage participants to develop action plans with the aim of achieving goals related to increasing functional independence, improving safety, decreasing depression and improving motivation as defined in the person-centered plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

6 OT visits and 4 RN visits and 1-2 visits of handy worker.
Usually, services are provided within 4-5 months but additional visits can be authorized based on medical necessary.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

DPH license and CAPABLE license

Certificate *(specify):*

Other Standard *(specify):*

complete CAPABLE training (online training takes about 8-12 hours)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and then every 2 years following

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

An electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. Personal Emergency Response System (PERS) services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
The services under the PERS service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Private vendor

Provider Qualifications

License *(specify):*

Regulations of CT. State Agencies 17-134-165

Certificate *(specify):*

Other Standard *(specify):*

Providers shall:
Provide trained emergency response staff on a 24-hour basis
Have quality control of equipment
Provide service recipient instruction and training
Assure emergency power failure backup and other safety features
Conduct a monthly test of each system to assure proper operation
Recruit and train community-based responders in service provision
Provide an electronic means of activating a response system to emergency medical and psychiatric services, police or social support systems.

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Initial and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Remote Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

This service includes the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Associated changes include expanding the list of authorized providers of PCA services to include adult day providers and remote support providers, adding certified community hubs as authorized provider types, and the addition of new rates for unscheduled back-up PCA services and remote live PCA services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The limitation of services provided by Remote Supports will be to work inside the allowable budget. If there is not room for added technology features or frequency of contact remotely, they will have to be purchased out of pocket. Each service plan will be tailored to the consumer and consumer's budget

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Congregate and other subsidized housing and Senior Center/municipalities.
Agency	Homemaking/Companion agencies
Agency	Adult Day Centers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Congregate and other subsidized housing and Senior Center/municipalities.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

Upon enrollment and then every 2 years following

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Homemaking/Companion agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Registered with the Department of Consumer Protection

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and then every two years following

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Adult Day Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and then every 2 years following

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Social Skills Group

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services assist individuals with the acquisition, improvement and /or retention of social skills necessary to achieve personal outcomes that increase an individual's independence, enhance an individual's ability to live and work in their community, and assist individuals in becoming responsible for their own actions as specified in the Individual Plan of care. The service is intended for specific instruction and training in social skills. Service can be provided face to face or using alternate means by all provider types.
The Autism Waiver Case Managers will be responsible for adding the service to the client's care plan that involves an alternate means of the delivery. Provider reports will indicate how the service was delivered as will a billing procedure code modifier to indicate an alternative means of service delivery.
Allowing services to be delivered in an alternative way will enable individuals to still receive services when they are unable leave their home environment and remain safe and successful.
By allowing social skills groups to be delivered in a virtual means important services in a client's plan can contribute to enhanced and increased independence by not allowing any interruption in services,
Delivering services in alternate means can continue to teach skills that are important to the participant for community interaction and integration.The participant will need to attest that they are in a private place in their environment, they consent to the alternatively delivered service and this will need to be documented in the providers report.
Any remote monitoring will meet HIPAA requirements and be accepted by the state's HIPAA compliance officer. This will be documented in the provider report and the case manager will document on client's service plan. The Case manager will assess back up plan prior to implementation and/or authorization of remote monitoring.
The use of remote monitoring and associated equipment will be individualized assessment and a part of the person-centered service plan. Ongoing monitoring and evaluation will be in place to confirm ongoing need for remote monitoring vs. in person services and supports. The state does not plan to utilize cameras that control does the individual have over the equipment. During development of person-centered service plan, participant will be advised of option to turn off remote monitoring device and/or equipment.
In-person activities continue to be a priority for the participant and telehealth will be used to supplement the scheduled in-person service based on the person-centered planning process.
Telephonic and virtual technology with 2-way video capability will be used.
The State does not provide the participant with equipment. The equipment being used is their own device which could be a laptop computer, tablet, telephone, or cellphone. The participant will know when their own equipment is on use. They will have the ability to relocate their own equipment to the setting in their environment in which they are most comfortable completing the visit.

This service may be used in combination with life skills coach, community mentoring or clinical behavioral supports services. This should be documented in the Individual Plan.
The services under the Social Skills Group Service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provision of these services is provided to groups of two or more participants who are limited to participating in only one group session per week.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Social Skills Group

Provider Category:

Individual

Provider Type:

Individual providers

Provider Qualifications

License *(specify):*

Psychologist

Licensed Clinical Social Worker

Licensed Marriage & Family Therapist

Licensed Professional Counselor

Certificate *(specify):*

Other Standard *(specify):*

Prior to Employment:
21 years of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of abuse/neglect, knowledge of policies prohibiting the use of physical management techniques
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
demonstrate knowledge of person-centered planning

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS and FI

Frequency of Verification:

Prior to employment and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Driving Assessment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services provide a pre-driving evaluation to determine if an individual can safely operate a motor vehicle. The evaluation will include a medical review, which includes verification of potential contraindications for driving, an in-house clinical evaluation which includes comprehensive visual, cognitive and physical screenings, simulation and on-the-road testing using a dual-equipped vehicle. This service does not include driver's education. This service is limited to individuals 18 years of age or older. Services will be provided by a team including a licensed Occupational Therapist and a Certified Driver Rehabilitation Specialist.
The services under Specialized Driving Assessment are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Driving Assessment

Provider Category:

Agency

Provider Type:

Private providers

Provider Qualifications

License *(specify):*

Occupational Therapist

Certificate *(specify):*

Certified Driver Rehabilitation Specialist

Other Standard *(specify):*

The agency must carry all applicable insurance.

The agency ensures that employees meet the following qualifications:
21 years of age
possess a valid Connecticut license
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required.

Prior to being alone with the Individual:
demonstrate competence and knowledge of state policies and procedures: abuse/neglect: incident reporting; client rights and confidentiality, handling of fire and other emergencies, prevention of abuse/neglect.

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS

Frequency of Verification:

Initial and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service is an inter-professional model delivered through a structured number of visits by a team comprised of a Care of Persons with Dementia in their Environments (COPE) certified occupational therapist (OT) and a COPE certified registered nurse (RN) to a participant as defined in the participant's person-centered plan. The service may include assessment and the development of a home treatment/support/action plan for this service, training and technical assistance to carry out the plan and monitoring of the individual and implementation of the service action plan. For participants without a dementia diagnosis, the service is referred to as "Confident Caregiver."

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Total 13 visits of services (10 OT, 3 RN visits; first OT and RN visit will take 2 hours each)
*Additional visits can be authorized based on medical necessity

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

DPH license

Certificate *(specify):*

COPE certificate (10 modules of COPE online training)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and then every 2 years following

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State of CT Department of Social Services

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal

history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ○ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure

that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Requests to permit payment to relatives/legal guardians for furnishing the following waiver services: community mentor, respite, non-medical transportation, individual goods and services, life skills coach, job coaching and interpreter are only permitted under consumer-directed services, and must be approved by the FI. The FI will ensure that the individual has engaged in recruitment activities and that there is a responsible person other than the paid family member, who, in addition to the participant, assumes employer responsibilities.

Circumstances where this may be permitted are limited to relatives/legal guardians who possess the medical skills necessary to safely support the individual, or, when the case manager and team determines that qualified staff are otherwise not available. Payment to family members is only made when the service provided is not a function that a family member would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family; and the service would otherwise need to be provided by a qualified provider.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All information regarding requirements for and instructions to enroll as a qualified provider for the HCBS waivers is posted on the DSS website.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of providers that conducted background checks as required by the state. Numerator = total number of providers requiring criminal background checks completed Denominator = total number of non-licensed and non-certified providers requiring criminal background checks

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: Contracted behavioral health ASO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new provider applications, by provider type, for which the provider obtained appropriate licensure/certification in accordance with State law

and waiver provider qualifications prior to service provision. Numerator= total number of new providers with proper licensure and certification Denominator= number of new providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Qualified provider application packet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment. Numerator = total number of providers meeting licensure and certification standards Denominator = total number of providers

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Contracted behavioral health ASO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of non licensed/non certified providers that had a criminal background check as required by the state. Numerator = total number of providers with required criminal background check Denominator = total number of non licensed/non certified providers with required criminal background check

Data Source (Select one):
Other
If 'Other' is selected, specify:
Criminal History Background checks

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted behavioral health ASO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of non-licensed/non-certified providers to meet waiver requirements. Numerator= total number of non-licensed/non-certified providers continuing to meet waiver requirements Denominator= number of non-licensed/non-certified providers

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Contracted behavioral health ASO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of non-licensed/non-certified provider applicants, by provider type, who met initial waiver provider requirements. Numerator = total number of non licensed/certified providers who meet initial waiver requirements Denominator = total number of non licensed/certified providers

Data Source (Select one):
Other
If 'Other' is selected, specify:

Employment applications, Criminal Hisory Background checks, and training records.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted behavioral health ASO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of providers, by provider type, that meet provider training requirements. Numerator = number of non-licensed/non-certified provider applicants who met initial waiver provider requirements Denominator = total number of providers

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: Contracted behavioral health ASO and training vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

A contract is in place with the Center for Children with Special Needs to provide quarterly training to new waiver providers. The curriculum is fully developed and approved by the department.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When issues are identified, qualified providers are required to submit a plan of correction with timeframes for completion. If a provider continues to have less than acceptable performance, the provider can be put on enhanced monitoring, can be prohibited from serving any new participants until the provider's performance has reached an acceptable level of quality, can lose qualified provider status for the service(s) with less than acceptable quality, and/or can be removed as a qualified provider altogether.
Potential providers must apply and submit organizational documentation to the DSS Division of Autism Services. Once the application is complete, the material is reviewed, the principal(s) of the organization is/are subjected to a background check and the executive team is interviewed by DSS staff. An organization that satisfactorily meets the expectation of all three steps above will be forwarded to the department's behavioral health ASO for final clinical review and approval.
Whenever an issue concerning the qualifications of an organization is identified through reviews or monitoring, the Director of Autism services will meet with the provider to discuss the issue(s). A plan of correction will be developed with timeframes for completion. If the provider fails to meet the items listed in the plan of correction or lacks the ability to demonstrate its capacity to maintain all the requirements, the provider will be placed on Enhanced Monitoring. A provider placed on Enhanced Monitoring will be downgraded to a conditional qualified provider status subject to additional monitoring by the department. Continued lack of progress on the identified issue(s) may result in disqualification of a particular service or as a provider for DSS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☒ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Each individual receives a budget allocation based on the results of their assessed Level Of Need. The Level of Need is determined as a result of the completed CT Level of Need Assessment and Risk Screening Tool (LON). The resulting score of 1-8 is associated with a prospective individual funding amount for home and community-based services. This assessment provides the information needed to accomplish the following objectives:
a)determine an individual's need for supports in an equitable and consistent manner for the purpose of allocating funding
b)identify potential risks that could affect the health and safety of the individual and support the development of a comprehensive Individual Plan to address potential risks
c)identify areas of support that may need to be addressed to assist the individual in actualizing personal preferences and goals.

Areas assessed by the LON include: health and medical, pica, behavior, psychiatric, criminal/sexual issues, seizure, mobility, safety, comprehension and understanding, social life, communication, personal care, and daily living. Scores in each domain are based on the amount of support the participant needs in that area. An algorithm is then applied that calculates the participant's overall need for support into a Composite score ranging from 0-8. Individuals with a composite score of 0 are not eligible to enroll in this waiver. Individuals with a score of 8 have exceptional support needs and will receive an allocation based on their individual support needs. Applicants with a score of 0 will not be eligible to receive waiver services since they will not meet the level of care criteria. Composite scores, much like overall IQ scores, are comprised of information obtained from answers on the assessment, and just as no two people with the same IQ score have the exact same skills, no two people with the same LON score have the same skills and risk areas. The CT LON Assessment and Manual are posted on the DDS website at https://portal.ct.gov/DDS/Family/LON/LON-Tool.

The participant is notified of the funding allocation. Adjustments to the budget allocation limit can be made either as a result of an assessed Level of Need which results in an increased or decreased LON allocation, or due to short-term circumstances necessitating an increased amount of services to address short-term health and safety needs.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

All services are provided in community locations or the individual's home. The state did not identify any services or settings that did not comply with the settings requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

DSS Case Managers are state employees who meet the following qualifications: considerable understanding of the nature of clinical assessments; considerable knowledge of services available to persons with autism spectrum disorders; knowledge of interdisciplinary approach to program planning; knowledge of autism spectrum disorders, characteristics and interventions; considerable skill in facilitating positive group process; oral and written communication skills; considerable ability to translate clinical findings and recommendations into program activities and develop realistic program objectives; ability to collect and analyze large amounts of information; familiarity with automated data systems.

General Experience:
Six (6) years of experience in working with individuals with autism spectrum disorders involving participation in an interdisciplinary team process and the development, review and implementation of elements in a client's plan of service.
Special Experience:
Two (2) years of the General Experience must have involved responsibility for developing, implementing and evaluating individualized programs for individuals with autism spectrum disorders in the areas of behavior, education or rehabilitation.
Substitutions Allowed:
1.College training may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years for a bachelor's degree.
2.A Master's degree in Counseling, Psychology, Special Education or Vocational Rehabilitation may be substituted for one (1) additional year of the General Experience.
3.A Master's degree in Social Work may be substituted for the General and Special Experience.
4.Two (2) years as a Social Worker Trainee in the Department of Developmental Services may be substituted for the General and Special Experience.
5.For State Employees one (1) year as a Social Worker with some experience working with individuals with autism spectrum disorders may be substituted for the General and Special Experience.
6.For State Employees two (2) years as a Supervising Developmental Services Worker 1, Supervising Developmental Services Worker 2, Developmental Services Supported Living Worker or Developmental Services Adult Services Instructor may be substituted for the Special Experience.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The case manager will support the waiver participant and other team members to develop and implement a plan that addresses the individual's needs and preferences. The case manager supports the individual to be actively involved in the planning process and assists the individual to identify members of his or her planning team and to invite them to the meeting. The case manager supports the individual to determine the content of the meeting and decide how the meeting will be run and organized. During the planning meeting, the individual and team discuss ways to enhance the individual's future participation in the planning process if needed. The case manager supports the individual and family to review assessments and reports before the meeting. The case manager is responsible to ensure the planning team meeting is scheduled at a time when the person, his or her family and other team members can attend. The case manager ensures the individual has a choice of supports, service options, and providers and that the plan represents the individual's preferences.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The individual planning process results in the development of an Individual Plan (IP) which is the document to guide all services and supports provided to the individual. The practice of person-centered planning is used as a way to develop the IP and is based on the kind of life a person desires. A person-centered plan maps out the individual's goals that he/she wishes to achieve and ensures access to needed services and supports. Person-centered planning is an approach to planning driven by a respect for the individual, a belief in the capacities and gifts of all people, and the conviction that everyone deserves the right to create their own future. The IP process promotes and encourages the person and those people who know and care for him or her to take the lead in directing this process and in planning, choosing, and evaluating services and supports. Person-centered planning puts the person at the “center” of the plan. Person-centered planning offers people the opportunities to lead self-determined lifestyles and exercise greater control in their lives. With individual planning, the person is viewed holistically to develop a plan of services and supports that is meaningful to him or her. Services and supports are identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks.

To access waiver services, a current IP, and accompanying individual budget, if applicable, must be developed or updated to identify specific needs, preferences and individual outcomes that will be addressed by waiver services. The IP serves as the Medicaid Plan of Care that supports and prescribes the need for the specific type(s), frequency, amount and/or duration of waiver services. Without a complete plan as described below, Medicaid waiver services cannot be authorized.

Once an individual is deemed eligible for waiver services, but prior to actual enrollment, he/she will be matched with a case manager who will assist them in developing an IP, coordinating the planning team and coordinating or performing assessments (as needed). The match will be based on skills and geography.

Following are the major steps of the IP planning process:

Prepare to plan.
The case manager develops strategies to assist the individual and his or her family (i.e. caregivers, significant others) to be actively involved in the planning process. The case manager and other team members assemble as much information as possible before the meeting to assist the individual and his or her family to prepare for the meeting. This helps the meeting to be more focused on decision making and more efficient.

The case manager will share the LON and LON Summary Report with team members prior to the planning meeting. In addition, the case manager will provide information from the various assessments including any bio-psychosocial assessments or other behavioral assessments. It is also helpful before the meeting to ensure that the individual and his or her family/representative(s) have a chance to review the information in current assessments, reports, and other evaluations that will be discussed at the meeting. Supporting the individual to prepare for the meeting offers an opportunity to express his or her desires or concerns to the case manager or another team member with whom he or she is comfortable and who can assist the individual to share these issues with the larger group. The case manager assists the individual to understand the waiver services and hiring options offered if the individual chooses to direct his or her own care for certain services.

There may be circumstances when the individual does not want to discuss something in a meeting. This preference should be respected when possible, however, personal information that affects supports or impacts the individual's health or safety must be addressed. In these circumstances, the topic should be acknowledged and dealt with respectfully and privately outside of the meeting with the individual and with others who need to know this information to provide appropriate supports.

Conducting the Planning Meeting and Developing the IP
The individual and his or her family members/representative(s) (as appropriate) should be comfortable with the people who help to develop the IP and should consider inviting a balance of people who can contribute to planning, including friends, family, support providers, and professional staff. The individual should be supported to include people in the planning and support team who:
- Care about the individual and see him or her in a positive light;
- Recognize the individual's strengths and take the time to listen to him or her; and
- Can make a commitment of time and energy to help the individual to develop, carry out, review and update the plan.

At the very minimum, the planning team shall include the individual who is receiving supports, his or her legal

representative, if applicable, his or her case manager, and persons whom the individual requests to be involved in the individual planning process. Depending upon the individual's specific needs, persons who provide supports and services to the individual should be involved in the individual planning process and may be in attendance at the individual planning meeting.

Every effort will be made to schedule the planning meeting at times and locations that will facilitate participation by the individual and his or her family, conservator, advocate or other legal representative, as applicable. The case manager will ensure that the individual and/or his or her family are contacted to schedule the meeting at their convenience.

If the individual, family, or legal representative refuses to participate in the IP meeting, the case manager shall document his or her attempt(s) to invite participation and the responses to those attempts in the individual record and in the Individual Plan. In these situations, the case manager shall pursue other ways to involve the individual, family, or guardian (if appropriate) in the planning process outside of the meeting.

The completion of the LON must include input from the individual, family, personal representatives, friends and service providers who know the person best. If a LON ultimately affects the amount, type or duration of waiver services, the individual and personal representative will be provided Fair Hearing Rights notice.

The result of the team meeting should be an initial IP that includes desired outcomes, needs or issues addressed, actions and steps, responsible person(s), timelines and should consider the individual’s choices and preferences. The IP must address each identified area that was identified by the LON as well as any information identified through other assessments (e.g. bio-psychosocial). If a new goal is required, then the ISP must include services or supports that are needed to address the goal.

Once the individual and team have completed the IP, they identify the type of services and supports that will address the goals in the IP. The IP will address coordination of waiver services with other services and natural supports. Specific agencies and/or individuals who will provide services or supports are further identified. The need for a waiver service that addresses specific outcomes must be clearly identified and supported by the Individual Plan. The case manager ensures that the individual and his or her family (as appropriate) or legal representative have sufficient information available to make informed selections of support providers, and information to make informed decisions regarding the degree to which the individual and his or her family or legal representative (as appropriate) may wish to self-direct services and supports.

During the planning meeting, the individual and team discuss plans to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. At a minimum, the case manager initiates a contact quarterly to evaluate the implementation or satisfaction with the plan, and visits the individual at each service site during the year to review progress on the plan. The team may be assembled to review the ISP any time during the year if the individual experiences a life change, identifies a need to change supports, or requests a review.

Once the IP is completed and the individual and planning and support team agree with the plan, the case manager ensures the plan is documented on the appropriate forms.

Implementing the Plan
Every effort should be made to arrange for needed supports and to implement the plan as soon as possible after the final approval is obtained as outlined above.

The role of the case manager in individual planning is to support the individual and other team members to develop and implement an IP that addresses the individual's needs. Case managers support individuals to be actively involved in the planning process. They are responsible for ensuring that individual planning meetings are scheduled at times when the person, his or her family and other team members can attend. The case manager is responsible for facilitating the individual planning meeting unless the individual requests another team member to facilitate the meeting. The case manager ensures the meeting is facilitated in line with the individual planning process and encompasses input across services settings.

The case manager ensures the plan is documented on the Individual Plan forms, though other team members or clerical staff may do the actual transcription of the plan. The case manager ensures the plan is distributed to all team members, though this task may also be assumed by another team member or clerical staff.

The case manager monitors implementation of the plan and ensures services and supports match the individual's needs and preferences. He or she ensures the plan is periodically reviewed and updated based on individual circumstances and regulatory requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Each waiver participant has a Level of Need Assessment which includes assessment of risk completed regarding his/her skills and circumstances, and reviewed with the Team at least on an annual basis. This tool produces a Summary Report that identifies all responses that may present a risk to the participant in medical, health, safety, behavioral and natural support areas. The team is required to address how each potential risk is mitigated in the Individual Plan. Included in this response is the use of an emergency back-up plan if the participant is reliant upon a paid or unpaid service to provide for basic health and welfare supports. Emergency back-up plans will be defined and planned for on an individual basis, and may include an assessment of critical services and a back-up strategy for each identified critical service. Back-up may include:

Informal back-up (e.g., family, friends, neighbors);
Enrolled providers offering habilitative services to the participant;
System level/local emergency response and crisis response.

In addition, information and training will be provided to every individual to prepare them for playing a greater role in developing their Individual Plan and the service delivery process. The information and training will cover health and safety factors, emergency back-up planning, and risk identification, assessment, and management.

As part of quality assurance reviews, DSS will review every Individual Plan to ensure that it meets health care needs and that there is proper documentation for emergency back-up and risk management procedures.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

All waiver participants are provided with a complete listing of all waiver service providers and provider selection process by the case manager at the time of the Individual Plan. This list of providers is also available on the DSS website. Waiver participants will choose providers from the list and their signature on the Individual Plan acknowledges freedom of choice.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The DSS autism waiver manager will authorize the Individual Plan. The review of the IP will be based on the following:

Completeness of plan which includes all necessary services (waiver and non-waiver services) being listed in terms of amount, frequency, duration and planned provider(s), including assurances of the consumer's freedom of choice of waiver and non-waiver providers;
Consistency of the plan with assessment information regarding consumer's needs; and
Presence of appropriate signatures.

The DSS autism waiver manager will review the Individual Plan within 15 business days after the consumer approves and signs the IP. Upon this review, DSS will approve, pend or deny the IP. DSS will determine if the cost of the waiver services necessary to ensure the participant's health and safety does not exceed the cost limit established in the waiver.

Once DSS approves the IP, the individual will be notified and offered enrollment into the waiver. If the IP is pended, DSS will request additional information regarding the participant's need. DSS may also make recommendations to the Individual Support Team and the participant regarding changes to services and service budgets. DSS may also deny the IP. Applicants or participants whose health and safety needs cannot be reasonably assured at their current level of assessed care and home and community-based services within the waiver will not be enrolled (or will be disenrolled if a current participant) in the waiver.

In the event that the applicant is denied enrollment or a current participant's services are being reduced or terminated, the applicant or participant will receive a Medicaid Notice of Action (NOA) regarding their right to a fair hearing in accordance with the rules of the Medicaid program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The DSS case manager is responsible to monitor the implementation of the Individual Plan. The case manager reviews: the Individual Plan at least every 6 months, at a minimum, and modifies the plan as needed; the vendor progress reports and also reviews progress on the plan during reviews at each service site; the fiscal intermediary monthly and quarterly expenditure reports for individuals who choose self-direction; and contacts through the Targeted Case Management service requirements. The case manager will meet with the consumer at the time of these reviews to determine if the plan is properly implemented and identifies any health or safety issues. The case manager will also address the effectiveness of the emergency back-up plan, discuss free choice of providers and will modify the plan, if needed.

During the planning meeting, the individual and his or her planning and support team discuss plans to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. The team reviews all areas of the Individual Plan when there are any changes in the individual's life situation, and at least annually, or more frequently as required by state or federal regulations. The IP includes all services and supports available to the person not just those offered through the waiver. The right to select other qualified providers or to use resources to self-direct is reviewed at least annually.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of of participants who have IPs that are adequate and appropriate to their needs as addressed in the assessment. Numerator=number of plans that are adequate and appropriate Denominator = total number of plans

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of IPs that address participant risk factors. Numerator = number of plans that address risk factors Denominator = total number of plans

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of IPs that address participant goals. Numerator =number of plans that address goals Denominator = total number of plans

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of IPs that were reviewed and updated as warranted on or before the participant's annual review date. Numerator = number of plans updated as warranted Denominator = total number of plans

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Number and percent of IPs that were revised as needed to address participants' changing needs as identified by changes in the level of need. Numerator = number of plans revised Denominator= number of plans

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants who received the duration of services authorized as specified in the service plan. Numerator= Number of participants receiving the duration of services as authorized in their plan Denominator= total number of participants whose records were reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received the pertinent services pertaining to their needs as specified in the service plan Numerator= Number of participants receiving the scope of services in their service plan Denominator= total number of participants whose records were reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received the amount of services as specified in the service plan. Numerator= percentage of participants who received the specified amount of services in their service plan Denominator= total number of participants whose records were reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Number and percent of participants who received the frequency of services as specified in the service plan. Numerator = Number of participants receiving the frequency of services as authorized in their service plan Denominator = total number of participants whose records were reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received the type of services as specified in the service plan. Numerator= Number of participants receiving the type of service specified Denominator=total number of participants receiving a specific service

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants who indicated their choice among waiver services as documented by their signature on the IP. Numerator = number of participants who indicated their choice among waiver services as documented by their signature on the IP Denominator = total number of IPs

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who indicated their provider choice as documented by their signature on the IP. Numerator = total number of participants who indicated their provider choice as documented by their signature on the IP Denominator = total number of IPs

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The waiver manager will review reports for all sub-assurances. If there is a problem, the waiver manager will contact the supervisor of the case manager to initially address the problem. If the problem persists, the case manager will be provided another training regarding service plan and budget development. If problem persists following the retraining, then disciplinary action will be taken.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Consumer-directed options will be provided for participants who choose to direct the development of their Individual Plans and to have choice and control over the selection and management of waiver services. Individuals may choose to have either or both employer authority and budget authority.

The Individual Plan process is designed to promote and encourage the individual and those people who know and care about him or her to take the lead in directing the process and in planning, choosing, and managing services and supports to the extent they desire. The development of the Individual Plan is participant led. During the planning process, services and supports are identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks. At the time of the planning process, the individual's case manager ensures the person and his or her family or personal representative have sufficient information available to make informed choices about the degree to which they wish to self-direct services and supports. The case manager also ensures the individual and his or her family or personal representative have information to make informed selections of qualified waiver providers. Case managers also notify individuals about their ability to change providers when they are not satisfied with a provider's performance.

Individuals who self-direct and hire their own workers have the authority to recruit and hire staff, review staff qualifications, review criminal background checks, determine staff duties, set staff wages and benefits within established guidelines, schedule staff, provide training and supervision, approve time sheets, evaluate staff performance, and terminate staff employment.

Individuals who self-direct by hiring their own staff will have a case manager to assist them to direct their plan of individual support. In addition to case management activities, case managers assist individuals to access community and natural supports. They assist individuals to monitor and manage the individual budgets. Case managers may provide support and training on how to hire, manage and train staff and to negotiate with service providers. They assist individuals to develop an emergency back-up plan and may assist individuals to access self-advocacy training and support.

The services of a fiscal intermediary (FI) are required for individuals who self-direct their services and supports. The FI assists the individual and/or family or personal representative to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of employment of service workers by the individual or family, including federal, state and local tax withholding/payments, processing payroll or making payments for goods and services and unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, support to enter into provider agreements on behalf of the Medicaid agency, and providing information and training materials to assist in employment and training of workers. This service is required to be utilized by individuals and families who choose to hire their own staff and self-direct some or all of the waiver services in their Individual Plan. The service will be delivered as an administrative cost and is not included in individual budgets.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the**

home of a family member.

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

An important part of pre-meeting planning is helping the individual understand the choices that are available. The case manager helps the individual to understand the waiver service options and hiring options that DSS provides to all consumers and explains the DSS portability process. A review of support options is especially important during periods of transition, such as during the transition from school-to-work, when funding resources become available to the individual, when major life changes occur, or when aging issues become apparent. An individual can begin planning to self direct at any time by contacting his/her case manager.
The case manager provides information about options to self-direct to the participants and their families at the time of the Individual Plan meeting and at any time the individual expresses an interest in self-direction. The fiscal intermediary (FI) has responsibility to provide fact sheets to individuals who are referred to them who choose to self-direct. Fact sheets include information about criminal background checks, abuse/neglect registry checks, employer responsibilities, hiring and managing your own supports, employee safety, workers' compensation and liability insurance. The FI ensures that individual provider qualifications and training requirements are met prior to employment and the appropriate forms to document that training are completed.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The state's practice is to allow participants the opportunity to self-direct their waiver services independently if they are able to do so or with assistance, if needed, from family members, advocates, or a representative of the participant's choosing, to help with the responsibilities of self-direction. A representative does not have to be a legal representative. The representative assumes responsibilities for the Agreement for Self-Directed Supports, which is reviewed with the representative and the participant, and signs the agreement. The Agreement for Self-Directed Supports includes the identification of areas of responsibility where the participant will require assistance. Any assistance needed as indicated in the agreement must be addressed in the participant's Individual Plan. The members of the participant's support team, including the case manager and service providers, are responsible for ensuring that the representative functions in the best interest of the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Job Coaching	☒	☒
Life Skills Coach	☒	☒
Live in Companion	☒	☐
Respite	☒	☒
Clinical Behavioral Support Services	☒	☒
Interpreter	☒	☒
Nutrition	☐	☒
Community Mentor	☒	☒
Non-Medical Transportation	☒	☒
Individual Goods and Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The fiscal intermediary is procured through a competitive Request For Proposal (RFP) process. Private not-for-profit and for-profit corporations and LLCs furnish these services. CT DSS pays the FI directly per the contract. Participants who self-direct must use a FI under contract with the state. Connecticut generally requires the re-bidding of FI contracts every five years.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

As of the writing of this renewal application, the state has completed the RFP process for the Fiscal Intermediary and is moving through the contract process with the provider, therefore these fees may require an update.

The fiscal intermediary is paid based on the following fee schedule:

i. Participants with payroll $125 per month;
ii. Participants with payroll and providers $125 per month;
iii. Participants with providers/no payroll $55 per month;
iv. Close out fee for terminations or transfers $50 per participant;
v. Set up/training fee for new participants hiring staff $125; and
vi. Cost of Living Allowance reports $50 per participant (this is only if the fiscal intermediary is asked to do something that falls outside and above and beyond normal reporting requirements; this would be a request that requires extensive additional work to complete and does not occur frequently).

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

Ensure that criminal history background checks are done on all prospective employees and verify training requirements of direct support workers are completed.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☒ **Other**

Specify:

The fiscal intermediary (FI) provides an enrollment packet to each individual to whom it provides fiscal intermediary services under their state contract. The enrollment packet includes the state's forms and information (employee application, fact sheet on employer liability and safety, criminal background and abuse/neglect registry checks, individual provider Medicaid agreement, employee and vendor agreement forms, individual provider training verification record and training materials).

The FI meets with each participant who is hiring individual providers to review all of the state and federal employer requirements.

The FI secures workers' compensation policies for each participant employer with employees who work 26 or more hours per week and for employers and employees who choose to have Workers' Compensation Insurance for employees who work fewer than 26 hours per week. The FI is responsible for filing criminal history background check, abuse/neglect registry check, driver's license checks, workers' compensation policies, and training verification records along with all state and federal employee and employer forms.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DSS conducts an annual performance review of the fiscal intermediary. The fiscal intermediary is responsible for providing the state with an independent annual audit of its organization and the state funds and expenditures under the agent's control. In addition, quarterly statements of expenditures against individual budgets are sent to the individual and the designated agency administrator. These statements are reviewed on a periodic basis by administration staff and the individual's case manager. In addition to the quarterly statements, an annual expenditure report is submitted for each participant that is reviewed by DSS and either accepted or sent back for clarification or changes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The role of the case manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs and preferences. Case managers support individuals to be actively involved in the planning process. Case managers share information about choice of qualified providers and self-directed options at the time of the planning meeting and upon request. Case managers assist the person to develop an individual budget and assist with arranging supports and services as described in the plan. They also assist the individual to monitor services and make changes as needed. Case managers share information regarding the ability to change providers when individuals are dissatisfied with performance.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Job Coaching	☐
Life Skills Coach	☐
Live in Companion	☐
Remote Supports	☐
Respite	☐
Enviornmental Accessibility Adaptations	☐
Personal Emergency Response System	☐
Clinical Behavioral Support Services	☐
Social Skills Group	☐
Interpreter	☐
Nutrition	☐
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	☐
Specialized Driving Assessment	☐
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	☐
Community Mentor	☐
Non-Medical Transportation	☐
Individual Goods and Services	☐
Assistive Technology	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

DSS informs individuals about their right to seek assistance from independent advocacy organizations (examples of advocacy organizations include, but are not limited to, Office of the Child Advocate, Autism Speaks, People First). Training will be offered to waiver participants with the purpose of enabling the participants to advocate for themselves for access to services and supports. Information about self advocacy as well as independent advocacy organizations is available on the DSS website. The DSS case manager will assist the participant with accessing information about independent advocacy if requested.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Individuals may, through the Individual Plan process, request the termination of self-direction and his or her Agreement for Self-Directed Supports. An individual/family may decide to terminate the Agreement for Self-Directed Supports and choose an alternative support service. The case manager discusses with the individual/family all the available options and resources available, updates the Individual Plan, and begins the process of referral to the selected options. Once the new option has been identified and secured, the case manager will fill out the form for termination of the individual budget. The form is sent within 10 business days to the FI, and the fiscal office representative. The individual and the support team meet to develop a transition plan and modify the Individual Plan. The DSS case manager ensures that the participant's health and safety needs are met during the transition, coordinates the transition of services, and assists the individual to choose a qualified provider to replace the directly hired staff.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Each individual who self-directs by hiring his or her own workers has an Agreement for Self-Directed Supports describing the expectations of participation. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self-Directed Supports:
Key requirements are:
1) To participate in the development and implementation of the Individual Plan process.
2) Funds received under this agreement can only be used for items, goods, supports, or services identified in the service recipient's Individual Plan and authorized individual budget.
3) To actively participate in the selection and ongoing monitoring of services and supports.
4) To understand that no one can be both a paid employee and the employer of record.
5) To authorize payments for services provided only to the recipient according to the Individual Plan and budget.
6) To enter into an agreement with the provider agency/agencies or individual support worker(s) hired. The agreement is outlined in the Individual Family Agreements with Providers and Employees and identifies the type and amount of supports and services that will be provided.
7) To submit timesheets, receipts, invoices, expenditure reports, or other documentation on the required forms to the fiscal intermediary on a monthly basis or within the agreed upon timeframe.
8) To review the FI expenditure reports on a quarterly basis and notify the case manager and FI of any questions or changes.
9) To follow the DSS Cost Standards and Costs Guidelines for all services and supports purchased with the DSS allocation.
10) To get prior authorization from the DSS to purchase services, supports, or goods from a party that is related to the individual through family, marriage, or business association.
11) To seek and negotiate reasonable fees for services and reasonable costs for items, goods, or equipment, and to obtain three bids for purchases of items, goods, or equipment costing over $2,500.
12) Any special equipment, furnishings, or items purchased under the agreement are the property of the service recipient and will be transferred to the individual's new place of residence or be returned to the state when the item is no longer needed.
13) To participate in the department's quality review process.
14) To use qualified providers enrolled by DSS.
15) To ensure that each employee has read the required training materials and completed any individual specific training in the Individual Plan prior to working with the person.
16) To offer employment to any new employee on a conditional basis until the Criminal History Background check, Driver's License check, and DDS Abuse Registry check has been completed. Anyone on the DDS Abuse Registry cannot be employed to provide support to the individual. The employee cannot begin employment until these checks have been completed.
17) To notify the case manager/broker when the individual is no longer able to meet the responsibilities for self-directed services.

The individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the above requirements with or without intent may disqualify the individual from self-directing-services. An Agreement for Self-Directed Supports can be terminated if the participant does not comply with the agreed upon requirements. The individual and the support team meet to develop a transition plan and modify the Individual Plan. The DSS case manager ensures that the participant's health and safety needs are met during the transition, coordinates the transition of services, and assists the individual to choose a qualified provider to replace the directly hired staff.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1
Year 2		3
Year 3		6
Year 4		8
Year 5		10

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Agencies with Choice are permitted and encouraged. Any DSS qualified provider may apply to be categorized as an "Agency with Choice." DSS requires specific assurances to enroll and be designated as an Agency with Choice organization through the submission of policies and procedures that support the control and oversight by the participants over the employees, and requires periodic participation in DSS-sponsored training and events in consumer direction.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

These background checks will be requested and compensated by the FI

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Criminal history and/or background investigations are not required

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

An initial funding range is provided to the participant by the case manager based on the Level of Need Assessment. Within that allocation, individuals design an individual budget to support the outcomes identified in the Individual Plan. The resource allocation ranges are derived from analysis of past utilization and costs for services used by like individuals based on assessed Level of Need as described in Appendix B of this application.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The case manager provides the individual with the resource allocation based on their assessed Level of Need in writing. Following the development of the Individual Plan, the individual may request additional funding based on identified needs. The request is reviewed by the DSS autism waiver manager or the manager's designee. Any denial of service/funding levels is communicated in writing to the participant or representative (if applicable) and includes the formal notice and request for a Fair Hearing.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Amendments are changes in the budget that add additional funds for new waiver services or additional waiver services and require a modification to the Individual Plan. Occasionally amendments can be changes that decrease funds in a budget if this is accompanied by the individual's new LON or a stated desire by the individual to decrease services. Adjustments are changes to existing individual budgets in amount or type of waiver service without a change in funding. The individual/family and case manager discuss the need for a change in the amount or type of a particular service or support that does not increase the total budget. When this change is within existing line items or results in a new line item without a change in the authorized allocation, a revision to the individual budget is required to effect the change. Individuals, who are self-directing and have an individual budget, may shift funds among waiver services authorized in their budgets up to the designated amount identified in policy without a change in the Individual Plan. When changes exceed the designated amount found in policy or include a new waiver service, a change in the Individual Plan is required. The case manager reviews the proposed changes with the autism waiver team. When the team is in agreement with the changes, the case manager has the option of updating the IP and all relative sections. The autism waiver manager or the manager's designee is required to authorize the change.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FI monitors expenditures and alerts the waiver participant and the case manager of any variance in line items prior to payment that exceed the quarterly budgeted amount for the specific line item where the variance occurred. The FI has a system to verify that the service or support or product billed is in the authorized individual budget prior to making payment. The FI is responsible to cover out of its own funds any payments that exceed what the state has authorized in the individual budget.

The participant and the case manager also receive a monthly expenditure report. The FI must provide the reports to the participant and the case manager by the 25th day of the month following the reporting period. The case manager monitors the monthly expenditure reports, and is responsible to review the expenditure reports against the approved Individual Plan and budget on at least a quarterly basis to monitor for under/over utilization. The autism waiver manager or the manager's designee reviews the quarterly reports for utilization and follows up with the case manager when there are significant variances in service utilization.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Applicants for and participants under this waiver may request and receive a fair hearing in accordance with the DSS' Medical Assistance Program. Participants are informed of the Fair Hearing process at the Individual Plan meeting. Applicants will receive a copy of the DSS W-1035, Freedom of Choice/Hearing Notification Form, during the first visit with the case manager. Applicants will also be informed of the Fair Hearings process in the Consumer and Family Guide to the HCBS Waivers, and in all correspondence related to the HCBS waiver program related to resource allocation and access to the HCBS waiver program. Anytime access to a HCBS waiver or services are denied, reduced or terminated, the participant and legal representative are notified by the autism waiver coordinator, or the coordinator's designee, through the Notice of Denial of Home and Community Based Services Waiver Services, and each notice includes a DSS Request for an Administrative Hearing.

Participants are eligible for Fair Hearings in the following circumstances:

Participant was not offered the choice of home and community-based services as an alternative to institutional care;
Participant was not offered the choice of provider;
DSS does not reach a determination of financial eligibility within standards of promptness;
DSS denies the application for any reason other than limitations on the number of individuals that can be served and/or funding limitations as established under this waiver;
DSS denies the application for the individual not meeting the level of care or other eligibility criteria;
DSS disapproves the Individual Plan;
DSS denies or terminates a service of the individual's choice;
DSS denies or terminates a payment to a provider of the individual's choice; or
DSS discharges an individual from this waiver.

In accordance with Connecticut Medicaid rules, a Notice of Action (NOA) will be sent to a waiver participant when any service is denied, reduced, suspended or terminated. The NOA and Freedom of Choice/Fair Hearing Notification will be provided in Spanish to support providing persons with limited English proficiency or non-English proficiency.

During the enrollment process, participants will be informed of their rights and provided information about the Fair Hearing and Grievance processes. At that time, participants will be informed that, if they file a grievance or appeal, services will continue while the grievance or appeal is under consideration.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individual Plans and budgets that exceed the resources allocated to the individual or the individual budget limits based on the Level of Need Assessment and additional information as presented by the support team proceed through utilization review (UR). Each waiver specifies circumstances where services can exceed established Level of Need limits. The Medicaid agency operates this process.

Review Process and Timeliness - Individual Plans and budgets are reviewed to evaluate the amount, type, frequency, and intensity of services directly related to health and safety needs of the individual, and desired outcomes based on the individual's preferences and needs as described below.

Requests for resource allocations exceeding original allocation or the individual budget limit may be addressed to the case management supervisor and then to the manager if the participant is dissatisfied with the supervisor's decision. If the request has been denied, the individual and personal representative will be offered the following options: 1) revise the service plan to fall within the original resource allocation; 2) request an informal negotiation with DSS to determine if a compromise can be reached; or 3) request that the decision be forwarded to the DSS Fair Hearings Unit for formal action and Medicaid Fair Hearing rights.

The individual and his or her personal/legal representative may request a review of any decision to which he/she/they claim to be aggrieved by the next level review authority (Director of the Community Options Unit). Such reviews will be completed within 10 business days.

The telephone contact and outcome of the discussion will be documented in the case manager's running case notes in the individual's master record.
For determinations of the Central Office Waiver Policy and Enrollment Unit that constitute a denial of or reduction in a waiver service, the case manager will provide information and forms to initiate an administrative hearing through the Department of Social Services.

DSS sends a letter to the individual/legal representative informing them of the denial of services/funding. The letter includes information about their right to appeal and the form for requesting an appeal and a statement that if an appeal is filed services will continue until the outcome of the Hearing Officer's decision is known.
Paper and electronic records of Service and Enrollment denials are kept in DSS Central Office. Notice of adverse actions, such as termination of Medicaid, which implicate continued waiver eligibility, are issued and maintained by DSS. The formal administrative hearings process is managed by DSS. Documentation of informal dispute resolution processes are maintained electronically and in hard copy at the Central Office.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Under this waiver, the quality of services provided is assured in several ways: maintaining established credentials for standards for prospective providers (including background checks for household employees) by a fiscal intermediary, which maintains the provider registry; an availability of clinical review of the plan of care by a Clinical Psychologist specializing in Autism Spectrum Disorders, working with the participants' care team; monitoring by the case manager at team meetings; and a process for follow-up of reported incidents.

DSS has standard contract language that addresses incident reporting for clients served. This language states as follows:

The Contractor shall submit to the Department's Program Manager an incident report detailing situations that have compromised the health and/or safety of clients served in the program. The incident report shall be submitted within five business days of the occurrence and shall include but not be limited to: client name, staff involved, date, time, details of the incident, an explanation of corrective action taken, and standard operating procedure established to prevent future incidences.

The Department has modified this language to be included in all service agreements for waiver program providers.

The Department has developed a Serious Reportable Incident form specific to the waiver. This incident reporting form has been fully deployed.

A Serious Reportable Incident is defined as any situation in which the waiver participant experiences a perceived or actual threat to his/her health and welfare or to their ability to remain in the community. These incidents include:

- Allegations of physical, sexual and psychological abuse, seclusion, violation of civil rights, mistreatment, neglect and exploitation
- Missing person
- Death of a waiver participant
- Unplanned hospitalization
- Possible criminal action
- Medication refusal
- Medical treatment due to accident or injury

A Sensitive Situation is any situation that does not fit within the above categories that needs to be brought to the attention of the Department of Social Services, within 48 hours of the occurrence, that would potentially threaten the waiver participant's health and welfare or ability to remain in the community, such as an admission into a substance abuse or psychiatric facility.

B. All members of the waiver participant's care planning team and service agency staff members are required to report critical incidents. Recipients of Critical Incident reporters include:
- Participant's care manager
- Participant's provider
- Participant and/or Conservator
- DSS Community Option Unit

Reporting Methods and Timeframes:

The provider, pursuant to the Serious Reportable Incident form, shall immediately notify DSS by telephone under any of the following circumstances:

- The major unusual incident requires notification of a law enforcement agency;
- The major unusual incident requires notification of child protective services;
- The provider has received inquiries from the media regarding a major unusual incident that has not been previously reported; or
- The major unusual incident raises immediate concerns regarding the individual's health and safety such that more immediate notification regarding the incident is necessary.

The form requires providers to submit a written incident report to the DSS the next business day following the providers' initial knowledge of any major unusual incident. On the business day immediately following receipt of the written

incident report submitted by the provider, DSS shall enter preliminary information regarding the incident through its online system.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case managers will ensure that each waiver participant, upon admission to the waiver, is provided fact sheets on abuse/neglect reporting. These will also be provided during Individual Plan meetings. During the Individual Plan meeting, a review of a participant's individual needs is conducted to identify methods of prevention if appropriate. People who direct their own supports receive additional materials to train their staff on abuse and neglect policies and reporting.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Community Options Unit investigates critical events or incidents, often in conjunction with the consumer's clinician who is best able to interview the consumer. Other parties are contacted and interviewed as appropriate. If a concern is raised about any matter that comes up while the consumer is under the programming of a provider, the provider is required to submit an incident report. The specific manner of follow-up for such concerns is determined by the nature of the allegation and the results of the investigation. Possible actions include the suspension or removal of a provider from the active registry and/or reporting to law enforcement or licensure agencies (e.g., Department of Public Health). Action to ensure the safety of a waiver participant who is at imminent risk occurs immediately. Additional follow-up with other entities include but are not limited to DSS units/divisions (e.g., Quality Assurance, Medical Policy, Legal), law enforcement, Department of Public Health may be necessary.

The Department has developed a web-based data system to manage incident reporting and related follow-up and analysis.

When a waiver participant is age sixty or older and it is deemed appropriate to contact Protective Services for the Elderly (PSE) as part of the investigation, the social worker will assure this is done. In addition, police are notified if any criminal action occurs. Any party involved in the investigation process may initiate contact with PSE or the police. All contacts with PSE and/or the police must be documented as part of the investigation process. PSE Statute 17b-450 - 461 provides the framework for the investigation of abuse or neglect. The Department tracks follow-up in its case management database.

The timeframes for response and investigation commencement are as follows:

Priority	Response Time
Imminent	Immediate
Emergency	Same Business Day
Severe	Next Business Day
Non-Severe	Within 7 Working Days

Follow-up and reporting to all parties including the participant/representative and other relevant parties must be completed within 45 days of the reported event.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Critical Incidents
The autism waiver manager will be responsible for overseeing the reporting and response to all critical incidents (including abuse and neglect) or events that affect waiver participants.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

DSS is responsible for assessing whether unauthorized restraints were utilized. This would be determined through our assessment process. We would utilize our critical incident reporting system to identify any use of restraints.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DSS is responsible for assessing whether unauthorized restrictive interventions were utilized. This would be determined through our assessment process. We would utilize our critical incident reporting system to identify any use of restrictive interventions.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DSS is responsible for assessing whether unauthorized seclusion was utilized. This would be determined through our assessment process. We would utilize our critical incident reporting system to identify any use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ( ) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of IPs that address participant risk factors. Numerator = number of plans that address risk factors Denominator = total number of plans

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents (including incidents of abuse, neglect, and exploitation) that were reported within required timeframes. Numerator = total number of incidents reported within required time frame Denominator = total number of incidents

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of participants who received information about how to identify and report abuse, neglect, and exploitation. Numerator = number of participants who received information about how to identify and report abuse, neglect and exploitation Denominator = total number of participants

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents (including incidents of abuse, neglect, and exploitation) that were investigated according to state procedures or investigated according to policy Numerator = number of incidents investigated according to policy and procedures Denominator = total number of incidents

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Other state agencies responsible for receiving reports regarding abuse and neglect		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and Percent of critical incidents where leading cause was identified.
Numerator= Number of critical incidents where leading cause was identified
Denominator= Total number of critical incidents

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of of critical incidents that are investigated by department staff according to guidelines in the waiver. Numerator= number of critical incidents investigated by department staff in accordance with waiver Denominator= total number of critical incidents

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of serious incident reports that are reported utilizing the web-based critical incident reporting system within 48 hours as required by the waiver. Numerator = number of critical incidents reported within required 48 hours, denominator = total number of critical incidents

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of Critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified in the approved waiver.
Numerator = number of critical incidents in which state adhered to follow up policy
Denominator =total number of critical incidents

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents where interventions were implemented.
Numerator= number of critical incidents where interventions were implemented
Denominator= Total number of critical incidents

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants that report restrictive interventions, restraint, seclusion, was used in which they required follow up according to policy Numerator= number of reports of restrictive interventions, restraints and/or seclusion which were remediated and followed up according to policy Denominator= total number of reports of restrictive interventions, restraints and/or seclusion

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who have a medical visit with a practitioner at least annually. Numerator= number of participants who see a practitioner annually Denominator = total number of participants

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants who seek age-appropriate preventive medical care. Numerator = number of participants who seek age-appropriate preventive care Denominator = total number of participants

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Health and safety issues are monitored by the autism case managers and management team on an ongoing basis. Safety risk assessments are conducted and are part of the Individual Plans. Individual-focused or systemic remedies can be implemented. Abuse and neglect allegations are reported, investigated and resulting recommendations are followed up until resolution at the regional and provider levels. The centralized incident management system is in place and fully functioning and allows for different methods of aggregating the data such as by type of incident or by provider.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When issues are identified, providers are required to submit a plan of correction with timeframes for completion. If a provider continues to have less than acceptable performance, they can be put on enhanced monitoring, or can be prohibited from serving any new participants until their performance has reached an acceptable level of quality, or can lose their status as a qualified provider for the service(s) with less than acceptable quality, and/or can be removed as a qualified provider altogether.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The autism waiver manager will assume responsibility for implementation of overall service access, planning and delivery (level of care and service planning) and for substantial elements of the quality system through provision of case management, quality review activities, system safeguards and the maintenance of administrative functions. DDS central office maintains responsibility for the Division of Investigations. DSS oversees provider credentialing and enrollment activities, and systemic oversight, evaluation and analysis of data related to provider performance, system safeguards, fiscal accountability, administrative authority and quality improvement.

DSS will use information and data collected by case management and the autism waiver coordinator. DSS will notify providers of needed corrective actions, and track follow-up on corrective action plans.

Individual provider licensing results reports are posted to the web. Summary deficiencies and subsequent follow-up are prepared quarterly for administrative monitoring and oversight. Statewide aggregate licensing results are prepared annually to identify trends for quality improvement.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Discovery data and the progress and success of remediation strategies from various reports outlined in Appendices A, B, C, D, G, and I will be aggregated and shared quarterly, semi-annually, annually or as needed by DSS with the autism services advisory council and other interest groups.

The Autism Services Advisory Council is responsible for trending, prioritizing, and recommending improvement strategies and system changes prompted as a result of analysis of discovery and remediation information. This committee meets periodically throughout the year to review data, make recommendations and follow up on status of improvement projects.
Advisory Council Membership includes individuals and families receiving waiver services and supports, family member of an individual with ASD, state agencies, and advocacy groups.

The purpose of this advisory council is to provide opportunity for input from consumers, providers, families and others and to review key quality findings and data trends in order to make recommendations for systems improvement that will have a positive impact on individuals and families receiving waiver services and supports with ASD.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The related committee structures discussed above address compliance with the six waiver assurances. Development and deployment of new information technology applications and management reports support new levels of data collection, management, aggregation and analysis, helping the department keep pace with positive system changes resulting from successful implementation of various improvement strategies.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ◉ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Department of Social Services has contracted with a fiscal intermediary to credential all providers seeking to provide services under this waiver. The FI maintains a directory of all credentialed providers. The providers, once credentialed, are required to enroll with the state's MMIS contractor (Gainwell). The FI also processes payroll and submits claims to the MMIS for all household employees. When the services are billed to the MMIS, they are billed through a portal that matches the claim against the authorized service plan. Gainwell reviews the claim for a matching service authorization, Medicaid eligibility and other elements.(i.e., spend-down requirements) before reimbursing the provider. Gainwell ensures that all services and corresponding claim payments are coded and properly documented.

The DSS Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and issues exceptions when appropriate for issues of non-compliance with the state's policy requirements. The Office of Quality Assurance activities extend to all DSS programs with staff located at the central and regional DSS offices. Functions are grouped into three major areas of focus: audits, quality control, and fraud and recoveries. Data analytics are performed quarterly.

All waiver providers are subject to audits performed by the QA. Overall audit demands and audit resources available to DSS QA impact the frequency of audit and waiver providers. These audits include ad hoc reviews when ACR or DSS HCBS staff or case managers alert QA to potential issues. Agencies must submit to DSS their audited financial statements annually.

Audits of payments to providers are most commonly performed on a universe of claim payments within a two-year period. A random sample of 100 claims is chosen. The auditor reviews supporting documentation maintained by the provider and claim information maintained by the department. The purpose of the review is to determine if services and associated payments were made in accordance with applicable state regulations. Errors identified in the sample are extrapolated to the universe of paid claims to arrive at a financial audit adjustment.: The sample size for each audit is determined by a statistician. Based on Connecticut General Statute Section 17b-99(d), the sample must be based on 95% confidence level. The Office of Quality Assurance, Audit Division is responsible for verifying whether corrective action has been taken. This verification would performed at a subsequent audit.

Providers are selected on a rotating basis for the various waiver types. The selection of a provider is based on total dollar payments and claim activity.
The objective of the audit is to review medical assistance payments made to a provider to determine whether the provider:
1. *rendered services to an eligible recipient;*
2. *submitted claims that properly reflected the type and amount of services rendered;*
3. *rendered services that were medically necessary;*
4. *maintained documentation that accurately accounts for services rendered and the medical necessity of such services;*
5. *complied with all applicable federal and state laws, regulations and policies;*
6. *properly billed all available third party insurance;*
7. *met all standards for licensure governing the type of service rendered; and*
8. *adhered to all terms and conditions of its Provider Agreement with the Department.*

The Department assesses financial errors against the provider if the Department identifies non-compliance with the above requirements.
The scope of the audit of a provider is based on a review of claims paid normally during a three year period. The audit includes an analysis of claim information maintained by the Department and a review of medical and administrative records maintained by the provider. Third party sources are contacted if the Department deemed such contacts to be necessary. The audit verifies whether the services billed complied with state laws, which requires the services to be billed in accordance with an approved plan and for approved state rates.
The Auditor of Public Accounts is responsible for a periodic independent audit of the waiver program.
The frequency of audits is determined by DSS's Director of Quality Assurance who oversees audits for the Department's programs. There is no specified frequency, however the frequency is similar to other providers of Medicaid services which is determined by the Director as he identifies the need.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial

accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims coded and paid for in accordance with reimbursement methodology specified in the approved waiver Numerator= Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver Denominator= Number of paid claims

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Reports from MMIS system

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *State MMIS contractor*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *State MMIS contractor*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percentage of claims submitted that were submitted for individuals enrolled in the waiver on the date services were rendered. Numerator = number of claims submitted for enrolled participants on the date of service rendered Denominator = number of claims submitted

Data Source *(Select one):*
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid***	☐ ***Weekly***	☒ ***100% Review***

Agency		
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *MMIS contractor*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *MMIS contractor*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
Number and percent of claims paid with documentation that services in the participants service plan were actually rendered Numerator= number of claims paid with documentation that services in the participants service plan were actually rendered Denominator= Total number of paid claims

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *MMIS contractor*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *MMIS contractor*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of rates that remain consistent with the approved methodology outlined in the waiver. Numerator = Number of rates that are consistent with the approved waiver methodology Denominator = total number of rates

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Department's Rate Setting Unit

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100%***

		Review
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

DSS has contracted with Gainwell as its MMIS contractor to maintain the payment records on services received and billed under the waiver. MMIS matches service authorizations loaded into the system by the care managers to ensure that all billed services are within a consumer's Individual Plan of care. The MMIS contractor (Gainwell) ensures that all services and corresponding claim payments are coded and properly documented. Providers are directed to utilize Community Options Unit staff who will coordinate with Gainwell and the provider to resolve the payment issue. Additionally, the fiscal intermediary will generate, at the Department's request, a report identifying non-reimbursable charges for self-directed services with an explanation.

Finally, computerized service documentation system allows for the tracking of expenditures for each client (approved cost of the plan) as well as the total waiver program. HCBS staff and case managers are available to respond to questions, and clarify for the consumer any issues related to the Cost of Care Plan or the Medicaid application process. This may also involve coordinating with DSS eligibility staff to ensure that the consumer's application is approved in a timely manner.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

For self-directed services, DSS assigns staff to manage the fiscal intermediary contract to ensure that communication occurs on an as needed basis with the fiscal intermediary. He/she is the liaison between the fiscal intermediary and eligibility and will communicate any issues that need to be resolved and follow up to ensure they are resolved. If the issue is not something that can be resolved, he/she will bring it to the attention of the waiver program manager who will intervene.

For individual claims problems that providers identify through feedback from the billing portal, the department has developed a specific email address in the financial eligibility unit of Community Options to respond individually to each email.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ ***No***

◉ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Electronic visit verification has been implemented for this waiver.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Rates were determined by the Department of Developmental Services(DDS) and verified for their reasonableness by the Reimbursement & CON Unit of the Division of Health Services of the Connecticut Department of Social Services (Department).
Pursuant to the Department Provider Manual, all schedules of payment for covered Medicaid program goods and services shall be established by the Commissioner of the Connecticut Department of Social Services and paid by the Department in accordance with applicable federal and state statutes and regulations. The Autism waiver (Waiver) service rates are based on historical rates developed by the DDS, indirect costs of 10%, Administrative add-on of 20%, and a CPI based an inflationary rate of 3%. Consumers, provider organizations and Department staff have had the opportunity to review the Waiver application and rates pursuant to the public notice. The waiver application is subject to review and approval by the committees of cognizance of the Connecticut state legislature prior to submission to CMS.
The rate structure for the program consists of 1) fee-for-service billing from an established fee schedule that pays uniform rates across providers; 2) usual and customary rates established individually with providers based on special provider need; 3)"up-to-max" rates that require manual pricing. Maximum allowable rate for services are established by the Department in its fee schedule. Rates do not vary for different providers of Waiver services. Assistive Technology; Individual Goods & Services; Specialized Driving Assessment are "up to max" rates. These costs are limited to the waiver maximum over five years for Assistive Technology; one year for Individual Goods & Services; and as prescribed in the participants Individual Plan for Specialized Driving Assessment.

The historical rates developed by the DDS were based on the following assumptions:
The clinical behavioral supports, non-medical transportation, PERS, and respite rates were based on HCBS Comprehensive and Individual Family Supports (IFS) waiver rates; the community mentor rate was the HCBS Comprehensive and Individual and Family Support (IFS) waiver rate for personal supports; and job coach and life skills coach also used the HCBS Comprehensive and IFS waiver rates for in home supports for direct hire. The social skills group was based on the CT Behavioral Health Partnership rate; the specialized driving assessment was the CT BRS rate; and the job coaching and living skills coaching used Department of Labor direct wage baseline and included adjustments for indirect, supervision and administrative costs. The assistive technology was a reasonable estimated cost of communication devices. Individual Goods and Services were based on HCBS Comprehensive and IFS waiver rates, with a lower amount for this waiver. Live-in companion and interpreter rates were developed in 2013 by DDS and are both in the HCBS waiver. The live-in companion rate was based on the DDS Rental Subsidy Guidelines. Interpreter services rates are included in the HCBS Comprehensive, IFS, and EDS waivers.

These previously approved increased provider rates which would expire on November 11, 2023 unless added to the base waiver documents, include the following:
3.5% increase in existing rates approved by CMS for all provider types covered under these 1915(c) waivers, already approved as a temporary measure retroactive to July 1, 2021 under the Appendix K. Of the 3.5% increase, 1.8% is included in the ARPA HCBS Spending Plan. This impacts all service rates other than those provider types and services specifically excluded. Excluded providers and services: Assistive Technology; Environmental Accessibility Modifications, Personal Response Systems, Skilled Chore, Specialized Medical Equipment, Individual Goods and Services, and all Self-Directed Services.
6% minimum wage increase, already approved as a temporary measure retroactive to August 1, 2021, for provider types where rates, as approved, are based on the state's minimum wage. This 6% minimum wage increase is pursuant to Public Act 19-4. Service rates impacted by the increase in the minimum wage: agency-based personal care assistants (PCAs), chore/homemaker, companion services, assisted living services, adult day health, recovery assistant, community mentor, and agency-based respite servi

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The Department has engaged with its Medicaid Management Information System (MMIS) provider Gainwell to develop a web-based claims portal where the case manager enters the authorized service plan into the portal and the providers bill claims through the portal. Claims are checked against the service plan authorized by the care manager. Services that were not authorized will deny. Effective with the approval of this renewal, all agency-based waiver providers will be enrolling directly with the Department through an enrollment wizard in the Gainwell system. One statewide agent, the department's behavioral health ASO, will perform all credentialing functions and providers will be unable to enroll without producing the credentialing document. Self-directed providers will continue to submit time sheets to the fiscal intermediary who will bill through the portal. This direct relationship between waiver providers and the department will enable improved communication and monitoring of providers' performance. The care plan portal will allow only authorized services to pay, ensuring compliance with the plan of care. Gainwell will be producing reports that will compare authorized services to actual paid claims so that areas or providers needing follow up can be identified. This also allows for trending analysis of utilization patterns. Problematic agencies are identified and remediation plans are initiated. Allied Community Resources is the current fiscal intermediary who bills Gainwell directly for self-directed services.
Payments are made by the Medicaid agency directly to the providers of waiver and State Plan services. There are provider agreements between the DSS and each provider of services under the waiver.
Payments for self-directed services are made by the fiscal intermediary on the client's behalf. The FI then bills the state's MMIS contractor. Payments for all waiver and other State Plan services are made through Connecticut's approved MMIS. DSS pays providers through the same fiscal agent used in the rest of the
Medicaid program.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program. DSS has contracts with a fiscal intermediary to maintain the payment records on self-directed services received and billed under this waiver. The MMIS billing portal will ensure that all waiver services billed emanate from an approved consumer plan of care and submits appropriate claims to MMIS through the claims payment subcontractor of the Department. Providers are required to obtain client signature for services and this is reviewed upon audit by DSS Division of Quality Assurance. The MMIS provider reviews the claims for Medicaid eligibility and other elements (i.e., spend-down requirements) before reimbursing the provider. It is the responsibility of the case manager to develop a plan of care in conjunction with the client and their circle of support, to prevent client care plans from exceeding cost caps and to ensure that designated services are actually being provided. Self-directed services require signature on timesheets. Agencies are required to retain record of service delivery in their files. Proof of service delivery can be detected upon audit by DSS Quality Assurance through record review of agency files and Fiscal Intermediary records. Electronic visit verification for this waiver has been implemented.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

○ ***No. The state does not make supplemental or enhanced payments for waiver services.***

◉ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

These previously approved increased provider rates and payments, which would expire on November 11, 2023 unless added to the base waiver documents, include the following:
Performance Supplemental Payments: On or before November 30, 2023, benchmark payments will be paid to providers effective for and calculated based on 2% of expenditures from July 1, 2023 through October 31, 2023. Benchmarks must be met no later than October 15, 2023, and are as follows: (a) Including the Department of Social Services' racial equity training as a required component of all new staff orientation and participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training. (iii). Beginning with payments to be made on or before March 31, 2024, and every six months thereafter, payments will be paid to providers who meet the following outcomes: (a) Decrease in avoidable hospitalization; (b) Increase in percent of people who need ongoing services discharged from hospital to community in lieu of nursing home; and (c) Increase in probability of return to community within 100 days of nursing home admission. Payments are based on up to 2% of expenditures for the 6 months that immediately precede each payment (other than the first outcome payment which will be based on the 4 months that immediately precede the first payment). If the total cost of the 2% payout is less than total funds available, excess funds will be prorated up to a maximum limit of 4% and paid to providers who qualify for the outcome payment. This higher limit of 4% will be based on availability of funds as approved within the ARPA HCBS Spending Plan. Providers who meet all of the performance measures will receive a full payment. Providers who meet fewer than the maximum possible number of performance measures will receive a partial payment based on the number of performance measures that they meet, in which meeting each measure is associated with a pro rata equal share of the total payment for the provider.
Quality Infrastructure Supplemental Payments: Payments will be made on or before November 30, 2023, and March 31, 2024 to providers who meet the benchmarks set forth below based on the greater of 5% of expenditures during the four calendar months that immediately precede the month in which the payment is made or $5,000. For purposes of determining the applicability of the $5,000 in lieu of the percentage, expenditures used as the basis of the payment are total HCBS expenditures for the provider across all programs. The following benchmarks apply and must be met no later than the first day of the month in which the payment is made: Benchmark for November 2023 payment – Providers have delivery system modifications complete; (c) Benchmark for March 2024 payment – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements***

under the provisions of 42 CFR §447.10.

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly

expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the***

waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*15324.92*	*7760.94*	*23085.86*	*351398.52*	*3361.38*	*354759.90*	*331674.04*
2	*16267.32*	*8073.12*	*24340.44*	*363344.85*	*3495.69*	*366840.54*	*342500.10*
3	*16920.87*	*8396.19*	*25317.06*	*375697.74*	*3637.26*	*379335.00*	*354017.94*
4	*17583.83*	*8733.78*	*26317.61*	*388471.71*	*3782.46*	*392254.17*	*365936.56*
5	*18320.41*	*9082.26*	*27402.67*	*401681.28*	*3934.92*	*405616.20*	*378213.53*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*
		Level of Care:
		ICF/IID
Year 1	*417*	*417*
Year 2	*580*	*580*
Year 3	*846*	*846*
Year 4	*854*	*854*
Year 5	*863*	*863*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The estimated Average Length of Stay (LOS) of 363 days was based on the most recent 372 initial report, which was for the reporting period 1/1/2021 - 12/31/2021.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The estimates are based upon the actual average waiver services costs for waiver recipients using 372 initial report for the period 01/01/2021 to 12/31/2021. These base costs were then trended by 4.0% per year based on the published May 2022 CPI for Medical Care. As the Department has done for all of its Medicaid waivers, utilization and cost trends were also adjusted based on projected length of stay and projected unduplicated recipients. Assumptions used for new services being added are as follows:
- Utilization of COPE and CAPABLE is based on the percentage of members over age 50 in CY 2022
- Units/user and average cost per unit for Environmental Modifications based on that found in the DDS Comprehensive waiver
- Utilization of Remote Services based on current utilization of PERS

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor D' was developed based on the actual average cost for all other Medicaid services for waiver recipients using 372 initial reports for the period 01/01/2021 to 12/31/2021 trended by 4.0% per year based on the May 2022 Medical CPI. These reports represent claims PAID by the Department's Medicaid program. This automatically excludes prescription drug costs for the dual eligibles since these are Medicare Part D costs that are paid by Medicare and denied by Department payment systems.

** Effective January 1, 2006, dual eligible recipients have automatically been enrolled into Medicare Part D plan. These prescription costs are paid by Medicare and therefore are removed in the States claim payment process.*

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G was based on the institutional costs found in the 372 initial report for non-waiver recipients for the period 01/01/2021 to 12/31/2021. The base cost data were trended by approximately 3.4% per year going forward using May 2022 CPI for nursing care.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' includes the cost of all other Medicaid services furnished while the individual is institutionalized. Factor G' was based on the 372 initial report for non-waiver recipients using 372 reports for the period 01/01/2021 to 12/31/2021. The historic cost data were trended by 4.0% annually based on the May 2022 CPI for medical care. The factor does not include the cost of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Live in Companion	
Respite	
Assistive Technology	
Clinical Behavioral Support Services	
Community Mentor	
Enviornmental Accessibility Adaptations	
Individual Goods and Services	
Interpreter	
Job Coaching	
Life Skills Coach	
Non-Medical Transportation	
Nutrition	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	
Personal Emergency Response System	
Remote Supports	
Social Skills Group	
Specialized Driving Assessment	
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Live in Companion Total:						***8679.84***
Live in Companion	*per month*	*1*	*12.00*	*723.32*	***8679.84***	
Respite Total:						***428695.62***
Respite, Direct Hire, Out Of Home, Individual per 15 min	*15 min*	*8*	*40.00*	*8.56*	***2739.20***	
Respite Agency, In Home, Individual	*15 min*	*8*	*1464.00*	*8.17*	***95687.04***	
Individual Respite Direct Unskilled Respite Care Not Hospice, per diem	*Per diem*	*1*	*2.00*	*392.61*	***785.22***	
Respite, Facility Based, per diem	*Per diem*	*1*	*2.00*	*428.05*	***856.10***	
Respite Agency, Out of Home, Individual	*15 min*	*8*	*127.00*	*9.16*	***9306.56***	
Individual, Respite Agency, Unskilled Respite Care, Not Hospice, per diem	*Per diem*	*4*	*2.00*	*412.34*	***3298.72***	
Individual, Respite Direct Hire, Unskilled Respite Care, Not Hospice, per 15 min	*15 min*	*26*	*1382.00*	*8.77*	***315123.64***	
Respite, Direct Hire, Out Of Home, Individual per diem	*Per diem*	*1*	*2.00*	*449.57*	***899.14***	
Assistive Technology Total:						***66930.64***
Assistive technology	*$5000 limit/5 years*	*56*	*1.00*	*1195.19*	***66930.64***	
Clinical Behavioral Support Services Total:						***1006271.80***
Clinical Behavioral Support Services	*15 min*	*229*	*127.00*	*34.60*	***1006271.80***	
Community Mentor Total:						***859211.04***

GRAND TOTAL:		***6390492.82***
Total Estimated Unduplicated Participants:		***417***
Factor D (Divide total by number of participants):		***15324.92***
Average Length of Stay on the Waiver:	*363*	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Mentor--Agency	15 min	184	404.00	8.82	655643.52	
Community Mentor--Direct hire	15 min	68	494.00	6.06	203567.52	
Enviornmental Accessibility Adaptations Total:						0.00
Enviornmental Accessibility Adaptations	$15,000/5 years	0	1.00	10245.26	0.00	
Individual Goods and Services Total:						89135.20
Individually directed goods and services	$1000 limit/year	154	1.00	578.80	89135.20	
Interpreter Total:						760.95
Interpreter services-sign language	15 min	1	35.00	10.82	378.70	
Interpreter services-language	15 min	1	25.00	15.29	382.25	
Job Coaching Total:						389449.52
Job coach - direct hire	15 min	8	85.00	12.59	8561.20	
Job coach - Agency	15 min	116	248.00	13.24	380888.32	
Life Skills Coach Total:						3293376.66
Life Skills Coach Direct Hire	15 min	71	938.00	12.59	838468.82	
Life Skills Coach Agency	15 min	301	616.00	13.24	2454907.84	
Non-Medical Transportation Total:						52960.60
Non-emergency transportation, per mile	per mile	23	1262.00	0.98	28445.48	
Transportation, wheelchair van, mileage	Per mile	1	100.00	1.84	184.00	
Non-emergency transportation per encounter/trip	Per trip	11	172.00	12.86	24331.12	
Nutrition Total:						3374.28
Nutrition	per service	4	39.00	21.63	3374.28	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:						0.00
Participant Training					0.00	

GRAND TOTAL:	6390492.82
Total Estimated Unduplicated Participants:	417
Factor D (Divide total by number of participants):	15324.92
Average Length of Stay on the Waiver:	363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Engagement to Support Goal Attainment and Independence (CAPABLE)	per unit	0	1.00	3000.00		
Personal Emergency Response System Total:						**6726.27**
PERS (2-way)	Per month	8	12.00	69.63	**6684.48**	
PERS (Install)	Install	1	1.00	41.79	**41.79**	
Remote Supports Total:						**0.00**
Remote Supports	per month	0	11.00	845.62	**0.00**	
Social Skills Group Total:						**184229.12**
Social Skills Group	15 min per person	128	163.00	8.83	**184229.12**	
Specialized Driving Assessment Total:						**691.28**
Specialized Driving Assessment	Per service	1	1.00	691.28	**691.28**	
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:						**0.00**
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	per unit	0	6.00	250.00	**0.00**	

GRAND TOTAL:	**6390492.82**
Total Estimated Unduplicated Participants:	**417**
Factor D (Divide total by number of participants):	**15324.92**
Average Length of Stay on the Waiver:	363

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Live in Companion Total:						**9027.00**
Live in Companion	per month	1	12.00	752.25	**9027.00**	
Respite Total:						**613375.54**
Respite, Direct Hire, Out Of Home, Individual per 15 min	15 min	10	40.00	8.90	**3560.00**	
Respite Agency, In Home, Individual	15 min	10	1464.00	8.50	**124440.00**	
Individual Respite Direct Unskilled Respite Care Not Hospice, per diem	Per diem	1	2.00	408.31	**816.62**	
Respite, Facility Based, per diem	Per diem	1	2.00	445.17	**890.34**	
Respite Agency, Out of Home, Individual	15 min	10	127.00	9.53	**12103.10**	
Individual, Respite Agency, Unskilled Respite Care, Not Hospice, per diem	Per diem	5	2.00	428.83	**4288.30**	
Individual, Respite Direct Hire, Unskilled Respite Care, Not Hospice, per 15 min	15 min	37	1382.00	9.12	**466342.08**	
Respite, Direct Hire, Out Of Home, Individual per diem	Per diem	1	2.00	467.55	**935.10**	
Assistive Technology Total:						**96954.00**
Assistive technology	$5000 limit/5 years	78	1.00	1243.00	**96954.00**	
Clinical Behavioral Support Services Total:						**1457657.74**
Clinical Behavioral Support Services	15 min	319	127.00	35.98	**1457657.74**	
Community Mentor Total:						**1240944.88**
Community Mentor--Agency	15 min	256	404.00	9.17	**948398.08**	
Community Mentor--Direct hire	15 min	94	494.00	6.30	**292546.80**	
Enviornmental Accessibility Adaptations Total:						**42620.28**
Enviornmental Accessibility Adaptations	$15,000/5 years	4	1.00	10655.07	**42620.28**	
Individual Goods and Services Total:						**128817.30**
Individually directed					**128817.30**	

GRAND TOTAL:	**9435048.24**
Total Estimated Unduplicated Participants:	**580**
Factor D (Divide total by number of participants):	**16267.32**
Average Length of Stay on the Waiver:	363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
goods and services	$1000 limit/year	214	1.00	601.95		
Interpreter Total:						**791.25**
Interpreter services-sign language	15 min	1	35.00	11.25	**393.75**	
Interpreter services-language	15 min	1	25.00	15.90	**397.50**	
Job Coaching Total:						**564350.02**
Job coach - direct hire	15 min	10	85.00	13.09	**11126.50**	
Job coach - Agency	15 min	162	248.00	13.77	**553223.52**	
Life Skills Coach Total:						**4761173.34**
Life Skills Coach Direct Hire	15 min	99	938.00	13.09	**1215563.58**	
Life Skills Coach Agency	15 min	418	616.00	13.77	**3545609.76**	
Non-Medical Transportation Total:						**76889.68**
Non-emergency transportation, per mile	per mile	31	1262.00	1.02	**39904.44**	
Transportation, wheelchair van, mileage	Per mile	1	100.00	1.91	**191.00**	
Non-emergency transportation per encounter/trip	per trip	16	172.00	13.37	**36794.24**	
Nutrition Total:						**4387.50**
Nutrition	per service	5	39.00	22.50	**4387.50**	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:						**56160.00**
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	per unit	18	1.00	3120.00	**56160.00**	
Personal Emergency Response System Total:						**8733.86**
PERS (2-way)	Per month	10	12.00	72.42	**8690.40**	
PERS (Install)	Install	1	1.00	43.46	**43.46**	
Remote Supports Total:						**96738.40**

GRAND TOTAL:	**9435048.24**
Total Estimated Unduplicated Participants:	**580**
Factor D (Divide total by number of participants):	**16267.32**
Average Length of Stay on the Waiver:	363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports	per month	10	11.00	879.44	96738.40	
Social Skills Group Total:						266348.52
Social Skills Group	15 min per person	178	163.00	9.18	266348.52	
Specialized Driving Assessment Total:						718.93
Specialized Driving Assessment	Per service	1	1.00	718.93	718.93	
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:						9360.00
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	per unit	6	6.00	260.00	9360.00	
				GRAND TOTAL:		9435048.24
				Total Estimated Unduplicated Participants:		580
				Factor D (Divide total by number of participants):		16267.32
				Average Length of Stay on the Waiver:		363

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Live in Companion Total:						9388.08
Live in Companion	per month	1	12.00	782.34	9388.08	
Respite Total:						922816.45
Respite, Direct Hire, Out Of Home, Individual per 15 min	15 min	15	40.00	9.26	5556.00	
Respite Agency, In Home, Individual	15 min	15	1464.00	8.84	194126.40	
Individual Respite Direct Unskilled					849.28	
				GRAND TOTAL:		14315059.94
				Total Estimated Unduplicated Participants:		846
				Factor D (Divide total by number of participants):		16920.87
				Average Length of Stay on the Waiver:		363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Not Hospice, per diem	Per diem	1	2.00	424.64		
Respite, Facility Based, per diem	Per diem	1	2.00	462.98	925.96	
Respite Agency, Out of Home, Individual	15 min	15	127.00	9.91	18878.55	
Individual, Respite Agency, Unskilled Respite Care, Not Hospice, per diem	Per diem	8	2.00	445.98	7135.68	
Individual, Respite Direct Hire, Unskilled Respite Care, Not Hospice, per 15 min	15 min	53	1382.00	9.48	694372.08	
Respite, Direct Hire, Out Of Home, Individual per diem	Per diem	1	2.00	486.25	972.50	
Assistive Technology Total:						147370.08
Assistive technology	$5000 limit/5 years	114	1.00	1292.72	147370.08	
Clinical Behavioral Support Services Total:						2209838.10
Clinical Behavioral Support Services	15 min	465	127.00	37.42	2209838.10	
Community Mentor Total:						1880892.58
Community Mentor--Agency	15 min	373	404.00	9.54	1437601.68	
Community Mentor--Direct hire	15 min	137	494.00	6.55	443290.90	
Enviornmental Accessibility Adaptations Total:						66487.62
Enviornmental Accessibility Adaptations	$15,000/5 years	6	1.00	11081.27	66487.62	
Individual Goods and Services Total:						195321.36
Individually directed goods and services	$1000 limit/year	312	1.00	626.03	195321.36	
Interpreter Total:						823.00
Interpreter services-sign language	15 min	1	35.00	11.70	409.50	
Interpreter services-language	15 min	1	25.00	16.54	413.50	
Job Coaching Total:						855473.71
Job coach - direct hire	15 min	15	85.00	13.61	17352.75	

GRAND TOTAL:	14315059.94
Total Estimated Unduplicated Participants:	846
Factor D (Divide total by number of participants):	16920.87
Average Length of Stay on the Waiver:	363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job coach - Agency	15 min	236	248.00	14.32	838120.96	
Life Skills Coach Total:						7231979.30
Life Skills Coach Direct Hire	15 min	145	938.00	13.61	1851096.10	
Life Skills Coach Agency	15 min	610	616.00	14.32	5380883.20	
Non-Medical Transportation Total:						116722.52
Non-emergency transportation, per mile	Per mile	46	1262.00	1.06	61535.12	
Transportation, wheelchair van, mileage	Per mile	1	100.00	1.99	199.00	
Non-emergency transportation per encounter/trip	Per trip	23	172.00	13.90	54988.40	
Nutrition Total:						7300.80
Nutrition	per service	8	39.00	23.40	7300.80	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:						87609.60
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	per unit	27	1.00	3244.80	87609.60	
Personal Emergency Response System Total:						13602.80
PERS (2-way)	Per month	15	12.00	75.32	13557.60	
PERS (Install)	Install	1	1.00	45.20	45.20	
Remote Supports Total:						150912.30
Remote Supports	per month	15	11.00	914.62	150912.30	
Social Skills Group Total:						403172.35
Social Skills Group	15 min per person	259	163.00	9.55	403172.35	
Specialized Driving Assessment Total:						747.69
Specialized Driving Assessment	Per service	1	1.00	747.69	747.69	
Training and Counseling Services for Unpaid						14601.60

GRAND TOTAL:	14315059.94
Total Estimated Unduplicated Participants:	846
Factor D (Divide total by number of participants):	16920.87
Average Length of Stay on the Waiver:	363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregivers Supporting Participants (COPE) Total:						
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	per unit	9	6.00	270.40	**14601.60**	
				GRAND TOTAL:		**14315059.94**
				Total Estimated Unduplicated Participants:		**846**
				Factor D (Divide total by number of participants):		**16920.87**
				Average Length of Stay on the Waiver:		363

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Live in Companion Total:						**9763.56**
Live in Companion	month	1	12.00	813.63	**9763.56**	
Respite Total:						**973341.81**
Respite, Direct Hire, Out Of Home, Individual per 15 min	15 min	15	40.00	9.63	**5778.00**	
Respite Agency, In Home, Individual	15 min	15	1464.00	9.19	**201812.40**	
Individual Respite Direct Unskilled Respite Care Not Hospice, per diem	Per diem	1	2.00	441.63	**883.26**	
Respite, Facility Based, per diem	Per diem	1	2.00	481.50	**963.00**	
Respite Agency, Out of Home, Individual	15 min	15	127.00	10.31	**19640.55**	
Individual, Respite Agency, Unskilled Respite Care, Not Hospice, per diem	Per diem	8	2.00	463.82	**7421.12**	
Individual, Respite Direct Hire, Unskilled Respite	15 min	54	1382.00	9.86	**735832.08**	
				GRAND TOTAL:		**15016591.15**
				Total Estimated Unduplicated Participants:		**854**
				Factor D (Divide total by number of participants):		**17583.83**
				Average Length of Stay on the Waiver:		363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care, Not Hospice, per 15 min						
Respite, Direct Hire, Out Of Home, Individual per diem	Per diem	1	2.00	505.70	1011.40	
Assistive Technology Total:						154609.45
Assistive technology	$5000 limit/5 years	115	1.00	1344.43	154609.45	
Clinical Behavioral Support Services Total:						2318191.96
Clinical Behavioral Support Services	15 min	469	127.00	38.92	2318191.96	
Community Mentor Total:						1975146.68
Community Mentor--Agency	15 min	377	404.00	9.92	1510895.36	
Community Mentor--Direct hire	15 min	138	494.00	6.81	464251.32	
Enviornmental Accessibility Adaptations Total:						69147.12
Enviornmental Accessibility Adaptations	$15,000/5 years	6	1.00	11524.52	69147.12	
Individual Goods and Services Total:						205087.05
Individually directed goods and services	$1000 limit/year	315	1.00	651.07	205087.05	
Interpreter Total:						855.95
Interpreter services-sign language	15 min	1	35.00	12.17	425.95	
Interpreter services-language	15 min	1	25.00	17.20	430.00	
Job Coaching Total:						900601.33
Job coach - direct hire	15 min	15	85.00	14.15	18041.25	
Job coach - Agency	15 min	239	248.00	14.89	882560.08	
Life Skills Coach Total:						7578741.80
Life Skills Coach Direct Hire	15 min	146	938.00	14.15	1937814.20	
Life Skills Coach Agency	15 min	615	616.00	14.89	5640927.60	
Non-Medical Transportation Total:						121267.96
Non-emergency transportation, per mile	per mile	46	1262.00	1.10	63857.20	

GRAND TOTAL:	15016591.15
Total Estimated Unduplicated Participants:	854
Factor D (Divide total by number of participants):	17583.83
Average Length of Stay on the Waiver:	363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation, wheelchair van, mileage	per mile	1	100.00	2.07	207.00	
Non-emergency transportation per encounter/trip	per trip	23	172.00	14.46	57203.76	
Nutrition Total:						7594.08
Nutrition	per service	8	39.00	24.34	7594.08	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:						91113.93
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	per unit	27	1.00	3374.59	91113.93	
Personal Emergency Response System Total:						14146.41
PERS (2-way)	Per month	15	12.00	78.33	14099.40	
PERS (Install)	Install	1	1.00	47.01	47.01	
Remote Supports Total:						156948.00
Remote Supports	per month	15	11.00	951.20	156948.00	
Social Skills Group Total:						424070.58
Social Skills Group	15 min per person	262	163.00	9.93	424070.58	
Specialized Driving Assessment Total:						777.60
Specialized Driving Assessment	Per service	1	1.00	777.60	777.60	
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:						15185.88
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	per unit	9	6.00	281.22	15185.88	
				GRAND TOTAL:		15016591.15
				Total Estimated Unduplicated Participants:		854
				Factor D (Divide total by number of participants):		17583.83
				Average Length of Stay on the Waiver:		363

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Live in Companion Total:						***10154.16***
Live in Companion	*per diem*	*1*	*12.00*	*846.18*	***10154.16***	
Respite Total:						***1027756.18***
Respite, Direct Hire, Out Of Home, Individual per 15 min	*15 min*	*16*	*40.00*	*10.02*	***6412.80***	
Respite Agency, In Home, Individual	*15 min*	*16*	*1464.00*	*9.56*	***223933.44***	
Individual Respite Direct Unskilled Respite Care Not Hospice, per diem	*Per diem*	*1*	*2.00*	*459.30*	***918.60***	
Respite, Facility Based, per diem	*Per diem*	*1*	*2.00*	*500.76*	***1001.52***	
Respite Agency, Out of Home, Individual	*15 min*	*16*	*127.00*	*10.72*	***21783.04***	
Individual, Respite Agency, Unskilled Respite Care, Not Hospice, per diem	*Per diem*	*8*	*2.00*	*482.37*	***7717.92***	
Individual, Respite Direct Hire, Unskilled Respite Care, Not Hospice, per 15 min	*15 min*	*54*	*1382.00*	*10.25*	***764937.00***	
Respite, Direct Hire, Out Of Home, Individual per diem	*Per diem*	*1*	*2.00*	*525.93*	***1051.86***	
Assistive Technology Total:						***163590.57***
Assistive technology	*$5000 limit/5 years*	*117*	*1.00*	*1398.21*	***163590.57***	
Clinical Behavioral Support Services Total:						***2436815.04***
Clinical Behavioral Support Services	*15 min*	*474*	*127.00*	*40.48*	***2436815.04***	
Community Mentor Total:						***2078148.48***
Community Mentor--Agency	*15 min*	*381*	*404.00*	*10.32*	***1588495.68***	
Community Mentor--Direct hire	*15 min*	*140*	*494.00*	*7.08*	***489652.80***	
Enviornmental						***71913.00***

GRAND TOTAL:	***15810511.31***
Total Estimated Unduplicated Participants:	***863***
Factor D (Divide total by number of participants):	***18320.41***
Average Length of Stay on the Waiver:	*363*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptations Total:						
Enviornmental Accessibility Adaptations	$15,000/5 years	6	1.00	11985.50	71913.00	
Individual Goods and Services Total:						215998.09
Individually directed goods and services	$1000 limit/year	319	1.00	677.11	215998.09	
Interpreter Total:						890.35
Interpreter services-sign language	15 min	1	35.00	12.66	443.10	
Interpreter services-language	15 min	1	25.00	17.89	447.25	
Job Coaching Total:						945825.52
Job coach - direct hire	15 min	16	85.00	14.72	20019.20	
Job coach - Agency	15 min	241	248.00	15.49	925806.32	
Life Skills Coach Total:						7978513.76
Life Skills Coach Direct Hire	15 min	148	938.00	14.72	2043489.28	
Life Skills Coach Agency	15 min	622	616.00	15.49	5935024.48	
Non-Medical Transportation Total:						127331.20
Non-emergency transportation, per mile	per mile	47	1262.00	1.14	67617.96	
Transportation, wheelchair van, mileage	Per mile	1	100.00	2.15	215.00	
Non-emergency transportation per encounter/trip	Per trip	23	172.00	15.04	59498.24	
Nutrition Total:						7896.72
Nutrition	per service	8	39.00	25.31	7896.72	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:						94758.39
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	per unit	27	1.00	3509.57	94758.39	
Personal Emergency Response System Total:						15689.21

GRAND TOTAL:	15810511.31
Total Estimated Unduplicated Participants:	863
Factor D (Divide total by number of participants):	18320.41
Average Length of Stay on the Waiver:	363

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS (2-way)	Per month	16	12.00	81.46	15640.32	
PERS (Install)	Install	1	1.00	48.89	48.89	
Remote Supports Total:						174108.00
Remote Supports	per month	16	11.00	989.25	174108.00	
Social Skills Group Total:						444520.56
Social Skills Group	15 min per person	264	163.00	10.33	444520.56	
Specialized Driving Assessment Total:						808.70
Specialized Driving Assessment	Per service	1	1.00	808.70	808.70	
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:						15793.38
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	per unit	9	6.00	292.47	15793.38	

GRAND TOTAL:	15810511.31
Total Estimated Unduplicated Participants:	863
Factor D (Divide total by number of participants):	18320.41
Average Length of Stay on the Waiver:	363